

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7121

## CERTIFICATE OF DEATH

Reg. Dist. No.

07104

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Murkirk, Md.</b> c. LENGTH OF STAY IN 1b <b>Murkirk, Md.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hosp.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Murkirk, Md.</b> d. STREET ADDRESS <b>Cheverly, Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles T. Adams</b> First Middle Last		4. DATE OF DEATH <b>June 6 1958</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/14/??</b> yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
13. FATHER'S NAME <b>Alexander Adman</b>		14. MOTHER'S MAIDEN NAME <b>Catharine</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Calvin Adams</b>	
17. INFORMANT <b>Calvin Adams</b>		Address <b>Murkirk Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive left cerebral infarction</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive arteriosclerosis</b> DUE TO <b>7 yrs</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death 3 weeks</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5/12</b> , 19 <b>58</b> to <b>6/6</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6/6</b> , 19 <b>58</b> , and that death occurred at <b>11:20 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Norman Donat Cimeau</b> M.D.		ADDRESS (Street, city or town, state) <b>3503 Perry St.</b> DATE SIGNED <b>6/6/58</b>	
PHYSICIAN'S NAME (Type) <b>NORMAN DONAT CIMEAU</b>		<b>Murkirk Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>6-10-58</b>	22b. DATE THEREOF <b>6-10-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Queen Chapel</b>	22d. LOCATION (City, town, or county) (State) <b>Murkirk Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry S. Washington</b> ADDRESS <b>467 N. St. N. W.</b>		24a. REGISTRY <b>1-2-58</b> DATE	24b. REGISTRAR'S SIGNATURE <b>W. S. Smith</b>

CERTIFICATE OF DEATH

1880

Age

James

William

Charles Brown

James Brown

John Brown

6-10-28 (Green Chapel) Kirk Kirk 2nd

James W. Brown (Nov 12 1880)

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7122 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07105

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

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1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>16 Mount Rainier</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>			d. STREET ADDRESS <b>3210 Perry Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>George Edward Ager</b>			4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-20-09</b>		9. AGE (in years last birthday) <b>48</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Iron Works</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Charles Ager</b>			14. MOTHER'S MAIDEN NAME <b>Annie Bell</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>709-09-1899</b>		17. INFORMANT <b>Edith Ager; same address as #2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (c) <b>Cardiovascular renal disease</b> DUE TO cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>June 30, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/5/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville Maryland.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>JUL 7 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Manner of Death		Occupation		Education	
Residence		Birthplace		Date of Birth	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Examination		Time of Examination		Place of Examination	
Medical History		Physical Examination		Mental Examination	
Laboratory Examinations		X-ray Examinations		Other Examinations	
Diagnosis		Prognosis		Treatment	
Disposition of Body		Burial Place		Burial Date	
Remarks		Remarks		Remarks	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07106

7183

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 1508 5th St., N. W.			
3. NAME OF DECEASED (Type or print) First Middle Last E. Maud Anderson				4. DATE OF DEATH Month Day Year 6 30 19 58			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/5/1909	
9. AGE (In years last birthday) 49 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Mrs. Pearl Mesta 1800 Fox Hall, N. W. Washington, D. C.		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME James E. Anderson			
14. MOTHER'S MAIDEN NAME Ann M. McIntry				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No -			
16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Decedent Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 465x Pulmonary tuberculosis, right lung DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) Pulmonary tuberculosis, 9 yrs., 6 months							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 602x Pulmonary tuberculosis, 9 yrs., 6 months							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 7/20 to 19 49, to 6/30 19 58, that I last saw the deceased alive on 6/30 19 58, and that death occurred at 6:45 PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Moe Weiss, M. D.				ADDRESS (Street, city or town, state) Glenn Dale Hospital			
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				DATE SIGNED 6/30/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 4, 1958		22c. NAME OF CEMETERY OR CREMATORY Solon		22d. LOCATION (City, town, or county) Middleburg, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Harris Roughton				ADDRESS Middleburg, Va.		24a. REC'D BY REGISTRAR DATE JUL 3 1958	
24b. REGISTRAR'S SIGNATURE							



CERTIFICATE OF DEATH

<p>NAME OF DECEASED                  [Faint handwritten name]</p>		<p>AGE                  [Faint handwritten age]</p>	
<p>SEX                  [Faint handwritten sex]</p>		<p>RACE                  [Faint handwritten race]</p>	
<p>DATE OF BIRTH                  [Faint handwritten date]</p>		<p>PLACE OF BIRTH                  [Faint handwritten place]</p>	
<p>DATE OF DEATH                  [Faint handwritten date]</p>		<p>PLACE OF DEATH                  [Faint handwritten place]</p>	
<p>CAUSE OF DEATH                  [Faint handwritten cause]</p>		<p>IMMEDIATE CAUSE                  [Faint handwritten cause]</p>	
<p>INTERVIEWED BY                  [Faint handwritten name]</p>		<p>DATE OF INTERVIEW                  [Faint handwritten date]</p>	
<p>SIGNATURE OF DECEASED                  [Faint handwritten signature]</p>		<p>SIGNATURE OF WITNESS                  [Faint handwritten signature]</p>	
<p>DATE OF SIGNATURE                  [Faint handwritten date]</p>		<p>DATE OF SIGNATURE                  [Faint handwritten date]</p>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7123

## CERTIFICATE OF DEATH

07107

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>14 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North Beach</b> d. STREET ADDRESS <b>Charlestown Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Allen</b> Last <b>Baker</b>		4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-19-90</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months <b>04</b> Days <b>x 2</b> Hours <b>00</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Policeman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Mrs. Marie T Baker</b>		Address <b>North Beach, Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pericarditis due to anemia</b> 260 X DUE TO <b>INTERCAPILLARY GLOMERULO SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>DIABETES MELLITIS</b> (c) <b>10 YEARS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b> <b>5 YEARS</b> <b>10 YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive Cardio Vascular Disease</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 1955</b> to <b>June 28, 1958</b> that I last saw the deceased alive on <b>June 28, 1958</b> , and that death occurred at <b>6:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wm. D. Conner</b> M.D.		ADDRESS (Street, city or town, state) <b>3503 Penny St</b> DATE SIGNED <b>6/28/58</b>	
PHYSICIAN'S NAME (Type) <b>Norman D. Conner</b>		<b>W T Raimen MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/2/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland.</b>	
24a. REC'D BY REGISTRAR <b>JUL 3</b>		24b. REGISTRAR'S SIGNATURE <b>W. T. Raimen</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07108

7184

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b. 2 months and 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 918 8th St., S. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lee Barnes				4. DATE OF DEATH Month Day Year 6 11 19 58			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Separated	8. DATE OF BIRTH 1/9/02	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min. -- -- -- --		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Johnnie Warren, Alexandria, Va., (landscaping)		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jim Barnes				14. MOTHER'S MAIDEN NAME Hattie Byrd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 250-12-4819		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary hemorrhage 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic carcinoma, left lung, with metastasis to ribs and chest wall DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 5 minutes 7 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/26, 1958, to 6/11, 1958, that I last saw the deceased alive on 6/11, 1958, and that death occurred at 11:30AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED M.D. Glenn Dale Hospital 6/11/58 ACTUAL SIGNATURE Moe Weiss, M. D. Glenn Dale, Md. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF 6-13-58		22c. NAME OF CEMETERY OR CREMATORY not known as yet		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Dean Shornton Johnson & Perkins				ADDRESS 4804 Ga. Ave		24a. REC'D BY REGISTRAR JUN 17 '58 24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>		<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>		<p>5. Time of death: _____</p>		<p>6. Place of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Immediate cause: _____</p>		<p>9. Underlying cause: _____</p>	
<p>10. Manner of death: _____</p>		<p>11. Signature of physician: _____</p>		<p>12. Signature of registrar: _____</p>	
<p>13. Signature of informant: _____</p>		<p>14. Signature of medical examiner: _____</p>		<p>15. Signature of coroner: _____</p>	
<p>16. Signature of funeral director: _____</p>		<p>17. Signature of undertaker: _____</p>		<p>18. Signature of cemetery: _____</p>	
<p>19. Signature of health officer: _____</p>		<p>20. Signature of registrar: _____</p>		<p>21. Signature of coroner: _____</p>	
<p>22. Signature of medical examiner: _____</p>		<p>23. Signature of coroner: _____</p>		<p>24. Signature of funeral director: _____</p>	
<p>25. Signature of undertaker: _____</p>		<p>26. Signature of cemetery: _____</p>		<p>27. Signature of health officer: _____</p>	
<p>28. Signature of registrar: _____</p>		<p>29. Signature of coroner: _____</p>		<p>30. Signature of medical examiner: _____</p>	
<p>31. Signature of funeral director: _____</p>		<p>32. Signature of undertaker: _____</p>		<p>33. Signature of cemetery: _____</p>	
<p>34. Signature of health officer: _____</p>		<p>35. Signature of registrar: _____</p>		<p>36. Signature of coroner: _____</p>	
<p>37. Signature of medical examiner: _____</p>		<p>38. Signature of coroner: _____</p>		<p>39. Signature of funeral director: _____</p>	
<p>40. Signature of undertaker: _____</p>		<p>41. Signature of cemetery: _____</p>		<p>42. Signature of health officer: _____</p>	
<p>43. Signature of registrar: _____</p>		<p>44. Signature of coroner: _____</p>		<p>45. Signature of medical examiner: _____</p>	
<p>46. Signature of funeral director: _____</p>		<p>47. Signature of undertaker: _____</p>		<p>48. Signature of cemetery: _____</p>	
<p>49. Signature of health officer: _____</p>		<p>50. Signature of registrar: _____</p>		<p>51. Signature of coroner: _____</p>	
<p>52. Signature of medical examiner: _____</p>		<p>53. Signature of coroner: _____</p>		<p>54. Signature of funeral director: _____</p>	
<p>55. Signature of undertaker: _____</p>		<p>56. Signature of cemetery: _____</p>		<p>57. Signature of health officer: _____</p>	
<p>58. Signature of registrar: _____</p>		<p>59. Signature of coroner: _____</p>		<p>60. Signature of medical examiner: _____</p>	
<p>61. Signature of funeral director: _____</p>		<p>62. Signature of undertaker: _____</p>		<p>63. Signature of cemetery: _____</p>	
<p>64. Signature of health officer: _____</p>		<p>65. Signature of registrar: _____</p>		<p>66. Signature of coroner: _____</p>	
<p>67. Signature of medical examiner: _____</p>		<p>68. Signature of coroner: _____</p>		<p>69. Signature of funeral director: _____</p>	
<p>70. Signature of undertaker: _____</p>		<p>71. Signature of cemetery: _____</p>		<p>72. Signature of health officer: _____</p>	
<p>73. Signature of registrar: _____</p>		<p>74. Signature of coroner: _____</p>		<p>75. Signature of medical examiner: _____</p>	
<p>76. Signature of funeral director: _____</p>		<p>77. Signature of undertaker: _____</p>		<p>78. Signature of cemetery: _____</p>	
<p>79. Signature of health officer: _____</p>		<p>80. Signature of registrar: _____</p>		<p>81. Signature of coroner: _____</p>	
<p>82. Signature of medical examiner: _____</p>		<p>83. Signature of coroner: _____</p>		<p>84. Signature of funeral director: _____</p>	
<p>85. Signature of undertaker: _____</p>		<p>86. Signature of cemetery: _____</p>		<p>87. Signature of health officer: _____</p>	
<p>88. Signature of registrar: _____</p>		<p>89. Signature of coroner: _____</p>		<p>90. Signature of medical examiner: _____</p>	
<p>91. Signature of funeral director: _____</p>		<p>92. Signature of undertaker: _____</p>		<p>93. Signature of cemetery: _____</p>	
<p>94. Signature of health officer: _____</p>		<p>95. Signature of registrar: _____</p>		<p>96. Signature of coroner: _____</p>	
<p>97. Signature of medical examiner: _____</p>		<p>98. Signature of coroner: _____</p>		<p>99. Signature of funeral director: _____</p>	
<p>100. Signature of undertaker: _____</p>		<p>101. Signature of cemetery: _____</p>		<p>102. Signature of health officer: _____</p>	

FOR STATE  
HEALTH DEPT.

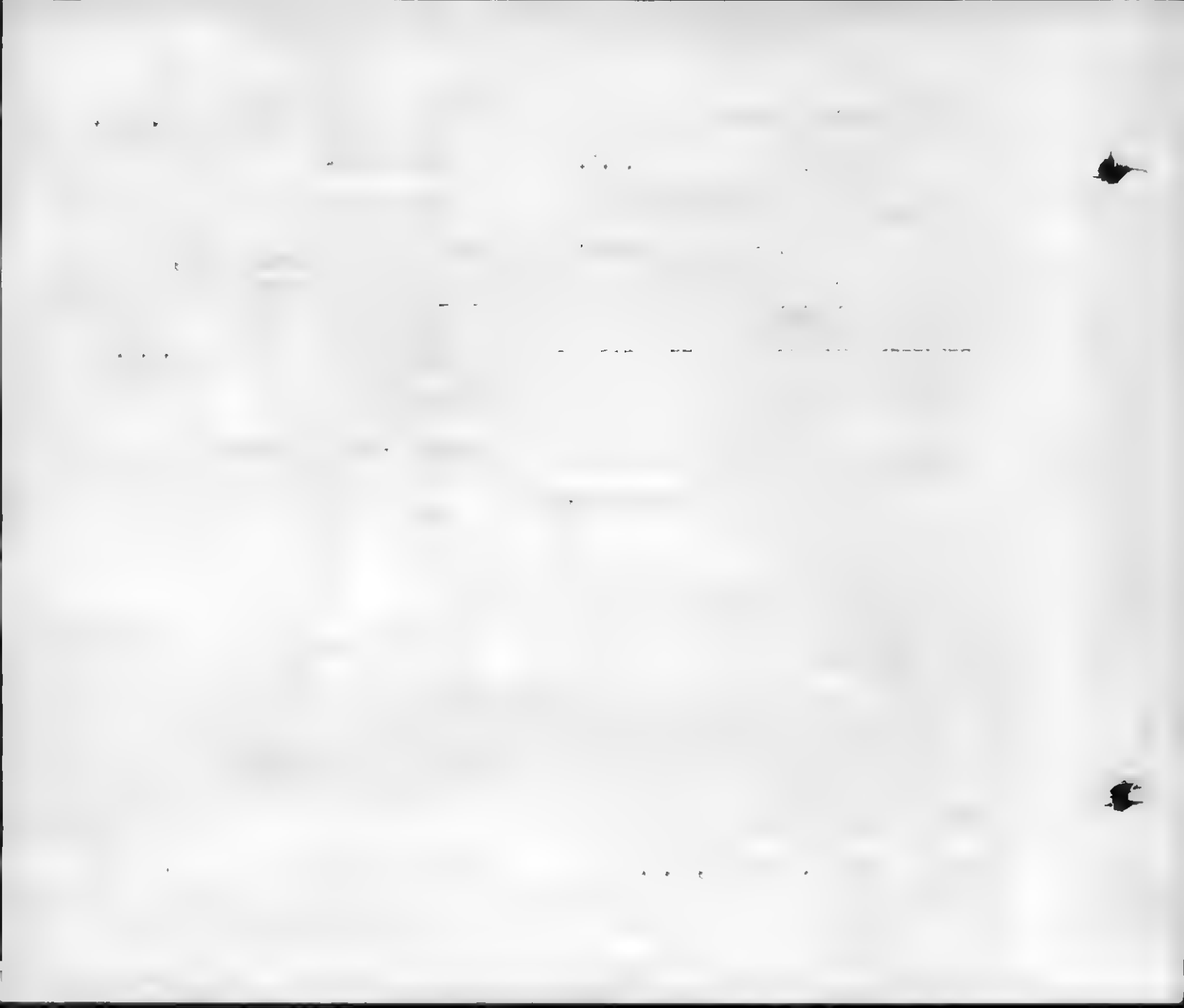
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7124 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07109

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berwyn Heights</b>	
f. STREET ADDRESS <b>5902 Osage Street</b>		<input type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Benjamin</b> Last <b>Beall</b>		4. DATE OF DEATH Month <b>June</b> Day <b>1,</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-16-58</b>
9. AGE (In years last birthday) <b>4</b> yrs		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Beall</b>		14. MOTHER'S MAIDEN NAME <b>Norma King</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Charles Beall; same address</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>June 1, 1958</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 3, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7185

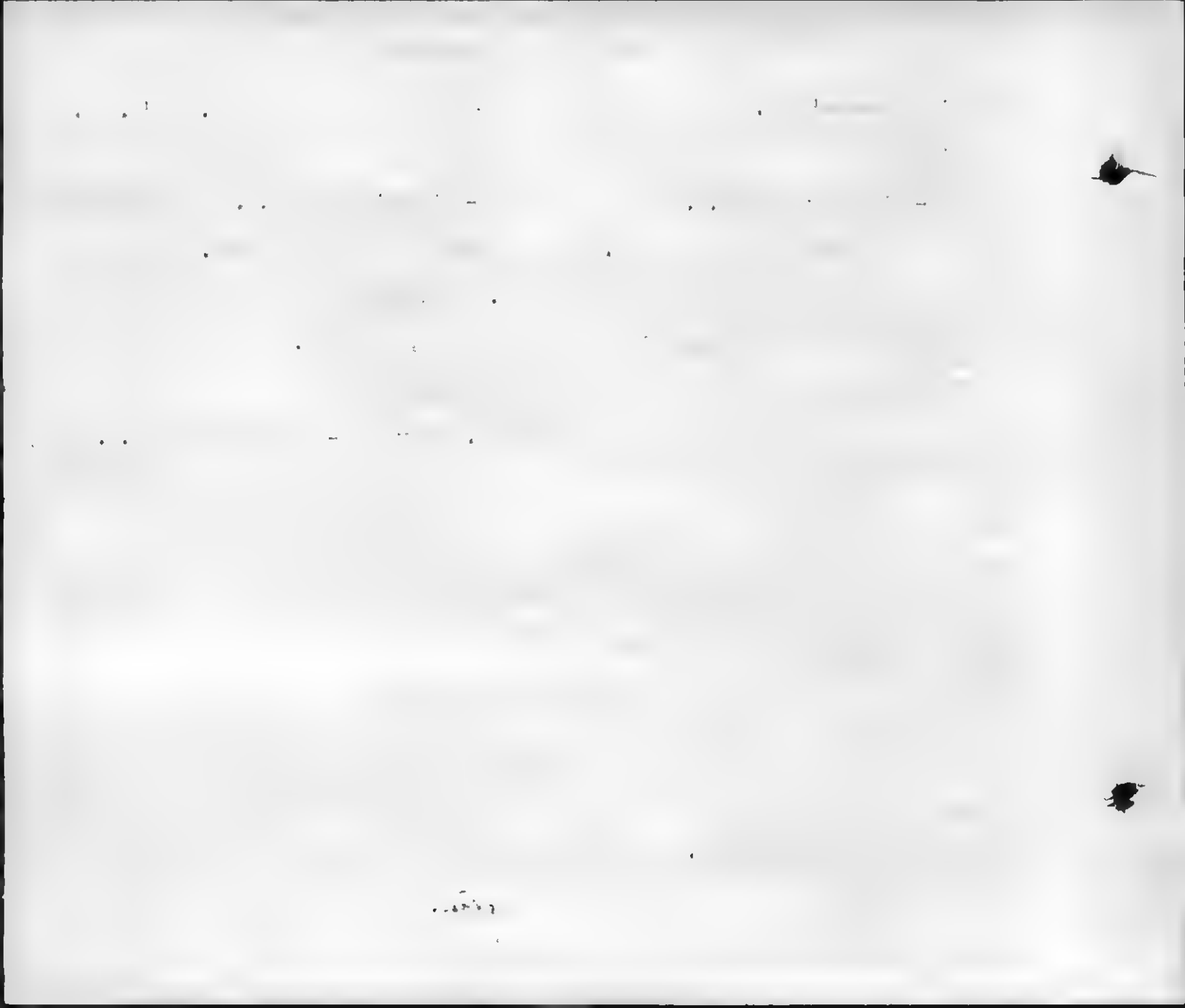
## CERTIFICATE OF DEATH

Reg. Dist. No. 07110

1. PLACE OF DEATH a. COUNTY <b>Prince George's Co.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's. Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silesia</b>				c. LENGTH OF STAY IN 1b <b>22 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8161 - Riverview Road S.E.</b>				e. STREET ADDRESS <b>8161- Riverview Road S.E.</b>			
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>GOLDIE R. BERRY</b>				4. DATE OF DEATH Month <b>June</b> Day <b>2nd.</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 9th 1893</b>		9. AGE (In years less birthday) yrs. <b>64</b>	10. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Silesia, Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Raum</b>				14. MOTHER'S MAIDEN NAME <b>Laura Taylor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <b>Samuel S. Berry 8161- Riverview Road S.E. (Hus)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Degeneration</b> <b>1744X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Circumstances of the Utterance</b> DUE TO <b>Myocardial Degeneration of Bladder</b> (c) <b>Secondary Anaemia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>3 yrs</b> <b>2 months</b> <b>2 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>May 19 57</b> to <b>May 23 19 58</b> , that I last saw the deceased alive on <b>May 23 19 58</b> , and that death occurred at <b>11 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Anna Coyne Todd M.D. 7519 Broadview Rd S.E. D.C. 22 6/2/58</b>							
ACTUAL SIGNATURE <b>Anna Coyne Todd</b>				PHYSICIAN'S NAME (Type) <b>ANNA COYNE TODD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 4- 58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington - Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sumner Bros 1661- 9th Hope Rd NE Wash DC</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 4 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





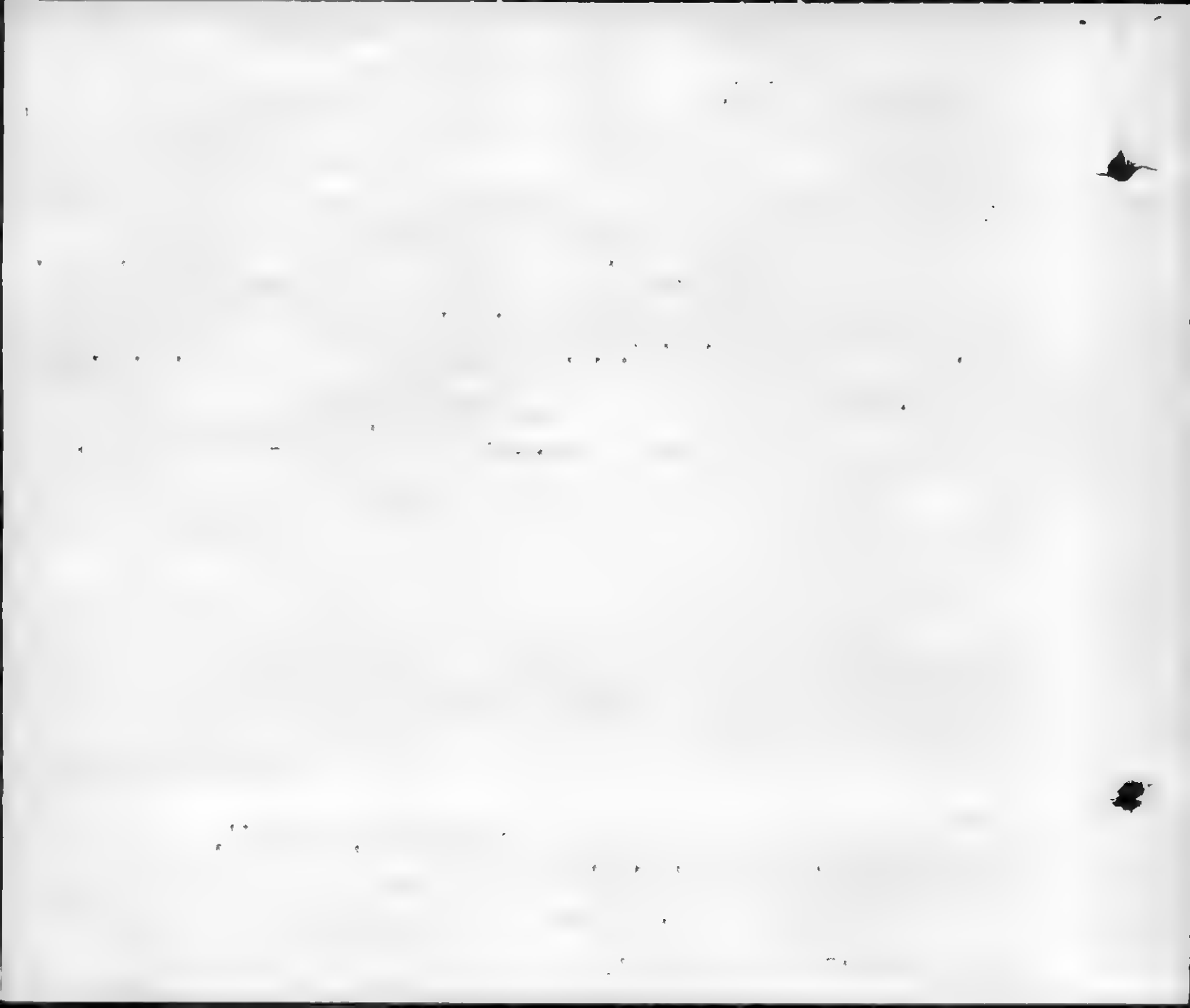
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7186  
CERTIFICATE OF DEATH

Reg. Dist. No. 07111

1 PLACE OF DEATH a. COUNTY <b>Prince Georges'</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges'</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Morningside</b>		c. LENGTH OF STAY IN 1b <b>2 1/2 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>11 Marianne Court</b>		e. STREET ADDRESS <b>11 Marianne Court</b>	
3 NAME OF DECEASED (Type or print) First <b>Harold</b> Middle <b>M.</b> Last <b>Bower</b>		4. DATE OF DEATH Month <b>June</b> Day <b>25</b> , 19 <b>58</b> .	
5. SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 18, 1894</b>
9 AGE (In years last birthday) <b>64</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Government (G.S.A.)</b>	
11 BIRTHPLACE (State or foreign country) <b>Indiana</b>		12 CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>James B. Bower</b>		14. MOTHER'S MAIDEN NAME <b>Laura Jackson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>----</b>	
17. INFORMANT <b>Harry W. Bower</b> Address <b>xxxxxx (Son)</b> ( <b>-same as above.</b> )			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, Generalized</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gastric ulcer</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6-9</b> , 19 <b>58</b> to <b>6-25</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6-25</b> , 19 <b>58</b> , and that death occurred at <b>1:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4223 Silver Hill Rd., Silver Hill, Maryland.</b> DATE SIGNED <b>6/26/58</b>			
ACTUAL SIGNATURE <b>John P. D'Angelo, M. D.</b>		PHYSICIAN'S NAME (Type) <b>John P. D'Angelo, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/28/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Bladensburg Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros.-Upper Marlboro, Maryland</b>		24a. REC'D BY REGISTRAR <b>JUL 1</b> 24b. REGISTRAR'S SIGNATURE <b>W. S. [unclear]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the Registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



07112

7125

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN lb <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eugene Leland Memorial Hospital</b>				d. STREET ADDRESS <b>817 Montgomery Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GEORGE</b>		First <b>HENNING</b>		Middle <b>BOYLE, SR.</b>		Last	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/26/93</b>	
				9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John S. Boyle</b>				14. MOTHER'S MAIDEN NAME <b>Erma Schmidt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction</b> DUE TO (c) <b>Pneumonia, arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>14 hrs</b> <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 10, 1956</b> , to <b>July 10, 1958</b> , that I last saw the deceased alive on <b>July 10, 1958</b> , and that death occurred at <b>10:15 A.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>3408 Rhode Island M Trainor, Md</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Dr. W. L. L. L. L. L.</b>		M.D. <b>3408 Rhode Island M Trainor, Md</b>					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>June 12, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Laurel Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Laurel Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Dr. W. L. L. L. L.</b>		ADDRESS <b>Laurel Md</b>		24a. REC'D BY REGISTRAR <b>John F. B. 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. L. L.</b>	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





7126

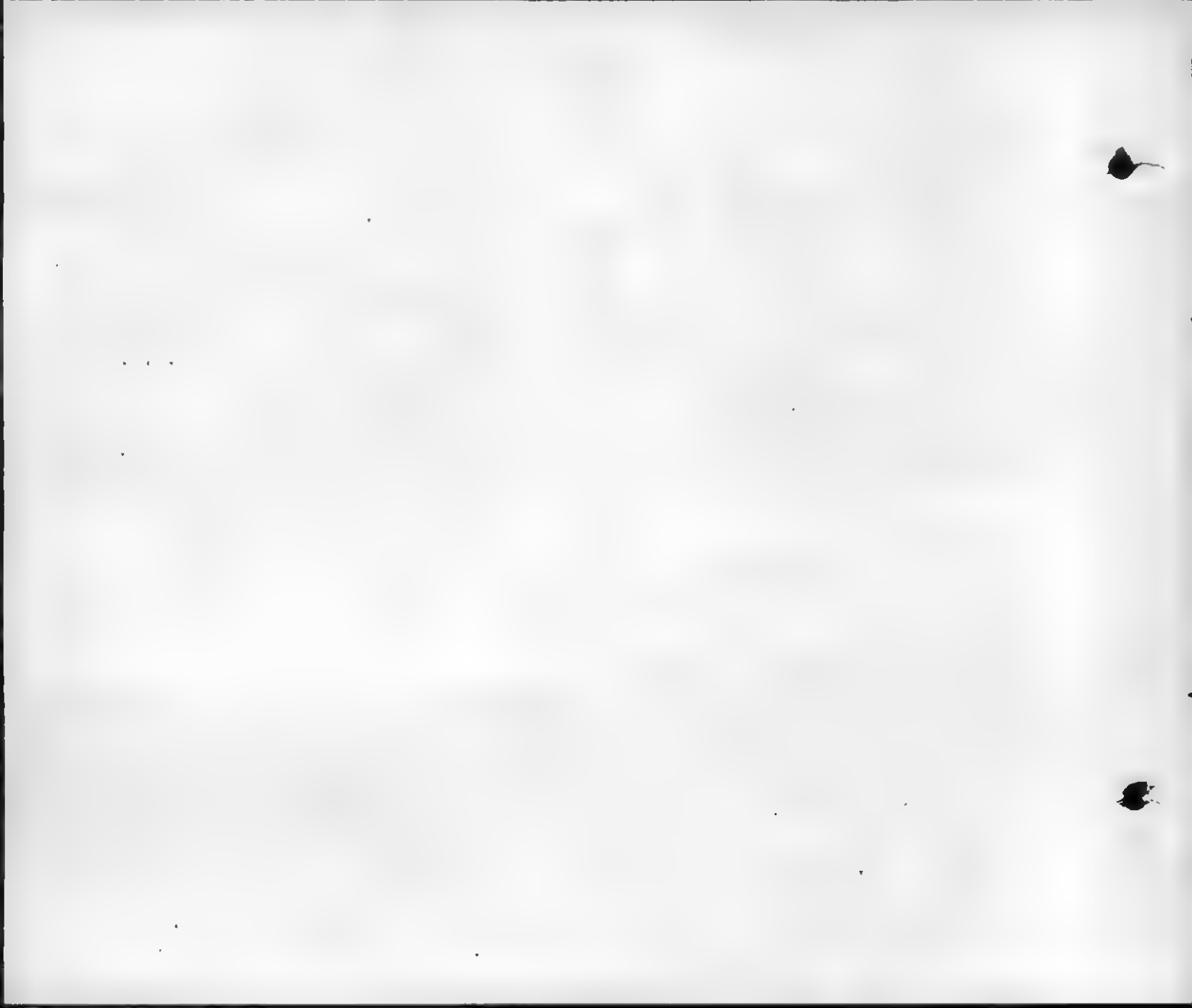
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brentwood 34</b> d. STREET ADDRESS <b>4316 40th pl.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Fitch</b> Last <b>Brinson</b>				4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 16 1890</b>	9. AGE (In years last birthday) <b>67</b> yrs	IF UNDER 1 YEAR Months <b>6</b> Days <b>29</b> Hours <b>19</b> Min <b>58</b>	IF UNDER 24 HRS. Months <b>6</b> Days <b>29</b> Hours <b>19</b> Min <b>58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert C. Fitch</b>				14. MOTHER'S MAIDEN NAME <b>Ida Johnson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>John Brinson</b> Address <b>Brentwood, Maryland.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b> <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>RHEUMATIC VALVULAR DISEASE</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.	Month, Day, Year <b>1958</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Colmar Manor, Md.</b>	(County)	(State)	
21. I certify that I attended the deceased from <b>June 29, 1958</b> to <b>June 29, 1958</b> , that I last saw the deceased alive on <b>June 29, 1958</b> , and that death occurred at <b>2:27 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Norman D. Comeau</b>		M.D. <b>3503 Perry St.</b>		DATE SIGNED <b>6/29/58</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Norman Comeau</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 2, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>			ADDRESS <b>Hyattsville, Maryland.</b>		24a. REC'D BY REGISTRAR <b>JUL 2 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07114

7127

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Washington D C</b> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly Md</b>		c. LENGTH OF STAY IN TB <b>pleasom anal</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. STREET ADDRESS <b>217 14th Place N E</b>	
3. NAME OF DECEASED (Type or print) <b>Edward Brown</b>		4. DATE OF DEATH <b>June 1, 1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 14, 1924</b>
9. AGE (in years last birthday) <b>34 yrs</b>		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car washer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>National Car Wash co</b>	
11. BIRTHPLACE (State or foreign country) <b>Lawndale N C</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>George W Brown</b>		Address <b>2426 15th Place S E Washington D C</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b); and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart aneurysm and shock</b> DUE TO (b) <b>Fracture of base of skull</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Passenger in auto that ran off Road</b>	
20c. TIME OF INJURY Month, Day, Year <b>June 6-1 1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 4</b>		20f. (City or town) <b>Forestville Pg Md</b> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type or print) <b>JAMES I. BOYD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>June 1, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6/2/58</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) <b>SPELBY P.C.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. ERNEST JARVIS CO.</b>		ADDRESS <b>1432 YOU St, NW (Wash) DC</b>	
24a. REC'D BY REGISTRAR <b>DATE JUN 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Ernest Jarvis</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, mailing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



7110

## CERTIFICATE OF DEATH

Reg. Dist. No

1 PLACE OF DEATH a. COUNTY <b>PRINCE GEO.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived) II institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville.</b>	
d. NAME OF HOSPITAL (if not in hospital give street address) OR INSTITUTION <b>5901 Knollbrook Drive</b>		d. STREET ADDRESS <b>5901 Knollbrook Dr. - apt 101</b>	
3 NAME OF DECEASED (Type or print) First <b>ALEXANDER</b> Middle <b>WILKINS</b> Last <b>BURNETT</b>		4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>1958</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/4/98</b>
9. AGE (In years last birthday) <b>59</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13 FATHER'S NAME <b>Alexander Wilkins Burnett.</b>		14 MOTHER'S MAIDEN NAME <b>Ella Boyd</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>414-46-7330</b>	
17 INFORMANT <b>Nell Burnett-wife</b>		Address <b>- Same.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Immed.</b> <b>1 1/2 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral pulmonary emphysema - severe.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>-</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>		20f. (City or town) (County) (State)	
21 I certify that I attended the deceased from <b>January</b> , 19 <b>57</b> , to <b>present</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>May 12</b> , 19 <b>58</b> , and that death occurred at <b>5:45 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William F. Simpson Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>6216 N. H. Ave N.E.</b>	
DATE SIGNED <b>6/6/58</b>			
PHYSICIAN'S NAME (Type) <b>WILLIAM F SIMPSON JR.</b>		<b>Washington, D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	22b. DATE THEREOF <b>6/7/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	22d. LOCATION (City town or county) (State) <b>Chattanooga, Tenn.</b>
23 FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		24a. REC'D BY REGISTRAR <b>2901 14th St. N.W.</b> <b>Washington 9, D.C.</b>	
24b. REGISTRAR'S SIGNATURE <b>W. Hines</b>		DATE <b>JUN 9 '58</b>	

Coroner Notified and will approve - *W. Hines*

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1  
FOR STATE  
HEALTH DEPT.

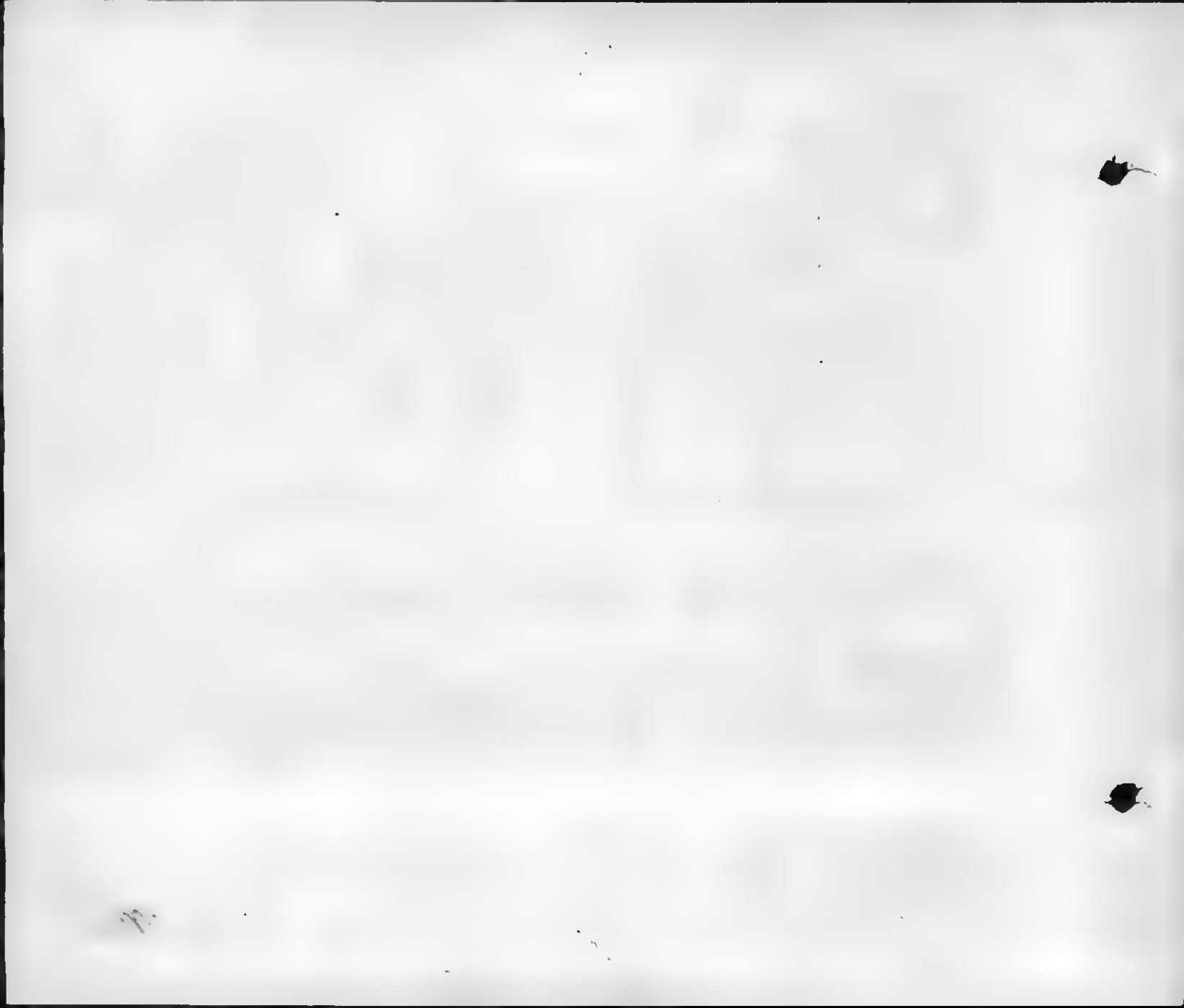
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7128 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>		c. LENGTH OF STAY IN 1b <u>20 hours</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>		d. STREET ADDRESS <u>Croom Station Road</u>	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>		e. IS FIELD SITE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Isaac</u>		4. DATE OF DEATH <u>June 16 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5 1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Burroughs</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie Blake</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1-1-1</u>	
17. INFORMANT <u>Alphonse Burroughs</u>		Address <u>1414 Wood Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhage and Shock</u> 812X DUE TO (b) <u>Compound fracture of right leg</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Crushed chest, Ruptured diaphragm</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Pedestrian struck by an automobile</u>	
20c. TIME OF INJURY Month, Day, Year <u>June 16 1958</u>	20d. INJURY OCCURRED <u>While at work</u>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 4</u>	20f. (City or town) <u>Upper Marlboro Md</u> (County) <u>Prince George's</u> (State) <u>Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>June 17 1958</u>	
22a. BURIAL-CREATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-20-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cemetery</u>	22d. LOCATION (City, town, or county) <u>Arlington, Va</u> (State) <u>Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Myrtle E. Collins</u>		ADDRESS <u>2227 14th St N.E. Wash D.C.</u>	
24a. REC'D BY REGISTRAR <u>June 20 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07117

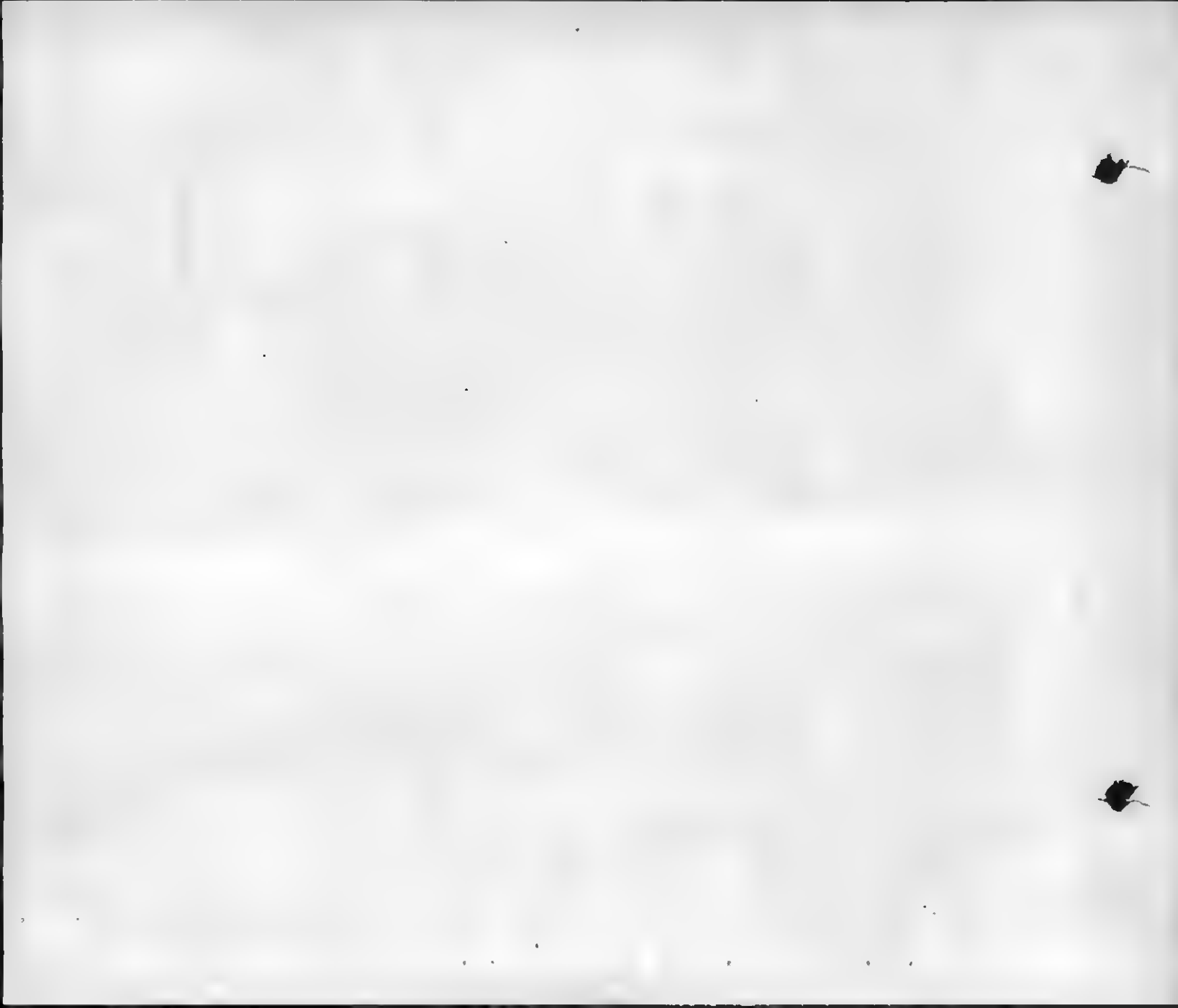
7129

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4609 Oliver Street</u>			d. STREET ADDRESS <u>4609 Oliver St.</u>		e. TO PERMITS ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Hazel</u> Middle <u>Rebecca</u> Last <u>Calhoun</u>			4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-25-94</u>	9. AGE (In years last birthday) <u>63</u> yrs	IF UNDER 1 YEAR Months <u>63</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auditor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C. U.S.A.</u>	
13. FATHER'S NAME <u>J. William Calhoun</u>			14. MOTHER'S MAIDEN NAME <u>Esther M. Calhoun</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1-1-1</u>		17. INFORMANT <u>Fanning Calhoun</u> Address <u>Same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>442X</u> DUE TO (b) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John T. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>June 23, 1958</u>	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/25/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county)	(State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>		ADDRESS <u>Wash. D.C. 2901 14th St., N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 25 '58</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>





CERTIFICATE OF DEATH

Reg. Dist. No.

07118

7187

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UPPER MARLBORO</b>		c. LENGTH OF STAY IN 1b <b>1 YEAR</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>4000 OLD MILL ROAD</b>		d. STREET ADDRESS <b>16 BRYANT ST. N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>ROSA</b> Middle <b>ETTA</b> Last <b>CATER</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>17</b> Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 15, 1884</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR: Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REGISTERED NURSE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NURSING</b>	
11. BIRTHPLACE (State or foreign country) <b>GEORGIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>SIMON HOWARD</b>		14. MOTHER'S MAIDEN NAME <b>MOLLY RAGLAND</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>JOSEPH CATER (SON)</b>		Address <b>4000 OLD MILL RD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>INANITION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>METASTATIC CARCINOMA OF THE BLADDER</b> DUE TO (c) <b>—</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b> <b>12 MOS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>OCT. 1957</b> to <b>JUNE 12, 1958</b> that I last saw the deceased alive on <b>JUNE 12, 1958</b> , and that death occurred at <b>12:00 Noon</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3904 ELM ST. UPPER MARLBORO</b> DATE SIGNED <b>6-17-58</b>			
ACTUAL SIGNATURE <b>Chett M. Cadenhead</b>			
PHYSICIAN'S NAME (Type) <b>—</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/21/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Akron, Ohio</b>	22d. LOCATION (City, town or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>—</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 19 '58</b>	24b. REGISTRAR'S SIGNATURE <b>—</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7111

## CERTIFICATE OF DEATH

07119

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville Nursing Home		d. STREET ADDRESS 3503 Metzrott Road	
3. NAME OF DECEASED (Type or print) First Middle Last HARVY NELSON CAVILEER		4. DATE OF DEATH Month Day Year June 8 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 7, 1871
9. AGE (In years last birthday) 86		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Peter Cavileer		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Gilbert Cavileer		Address College Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arterio-sclerotic Cardio-vascular disease. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1958 to June 1958, that I last saw the deceased alive on June 7, 1958, and that death occurred at 12:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. L. Etienne		ADDRESS (Street, city or town, state) 4713-Berwyn Rd College Park, Md	
PHYSICIAN'S NAME (Type) W. L. ETIENNE		DATE SIGNED 6/8/58	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/10/58	
22c. NAME OF CEMETERY OR CREMATORY Greenlawn		22d. LOCATION (City, town, or county) (State) Newport News VA	
23. FUNERAL DIRECTOR'S SIGNATURE F. Suscha sons		24a. REC'D BY REGISTRAR JUN 11 1958	
ADDRESS Hyattsville Md		24b. REGISTRAR'S SIGNATURE W. H. Beach	
DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07120

7188

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>-</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>		c. LENGTH OF STAY IN 1b <u>2 yrs., and 1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>478-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>				d. STREET ADDRESS <u>311 1/2 G. St., S. E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Delores</u> Middle <u>M.</u> Last <u>Chambliss</u>				4. DATE OF DEATH Month <u>6</u> Day <u>23</u> Year <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/24/34</u>		9. AGE (In years last birthday) <u>24</u> yrs.	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Shelby</u>				14. MOTHER'S MAIDEN NAME <u>Leslie M. Murphy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>579-40-3483</u>		17. INFORMANT <u>Decedent</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary tuberculosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-</u> DUE TO (c) <u>-</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs., 9 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>o. n.</u> <u>19</u> p. m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>6/22</u> , 19 <u>56</u> , to <u>6/23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/23</u> , 19 <u>58</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Moe Weiss</u>		M.D. <u>Glenn Dale Hospital</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>6/23/58</u>	
PHYSICIAN'S NAME (Type) <u>Moe Weiss, M. D.</u>		Glenn Dale, Md.					
22a. <del>CREMATION</del> CREMATION, <input checked="" type="checkbox"/> REMOVAL (Specify) <u>6/24/58</u>		22b. DATE THEREOF <u>6/24/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Palmer Funeral Home 412 H St NE</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 26 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Edruch</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

07121

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>715-58th Ave, N.E.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MAL K I A H</u> First Middle Last				4. DATE OF DEATH Month <u>6</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-11-1871</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Malkiah</u>				14. MOTHER'S MAIDEN NAME <u>Charity</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>101-11-1111</u>			
17. INFORMANT <u>Leahy Margaret</u>				Address <u>Portville Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X</u> DUE TO <u>Coronary disease acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) DUE TO <u>Heart disease Mitral disease</u> (c) <u>1-11</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>6/9</u> , 1958, to <u>6/10</u> , 1958, that I last saw the deceased alive on <u>6/10/58</u> , 1958, and that death occurred at <u>1 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Francis Dye R.</u>				ADDRESS (Street, city or town, state) <u>1107-0-58-1111-1111 N.C.</u>			
DATE SIGNED <u>6-10-58</u>							
PHYSICIAN'S NAME (Type) <u>J. FRANCIS DYE R.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6-13-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. Wilson + Woodford</u>				ADDRESS <u>1622-11-58-1111</u>		24a. REC'D BY REGISTRAR <u>JUN 10 58</u>	
24b. REGISTRAR'S SIGNATURE <u>West</u>							





7190

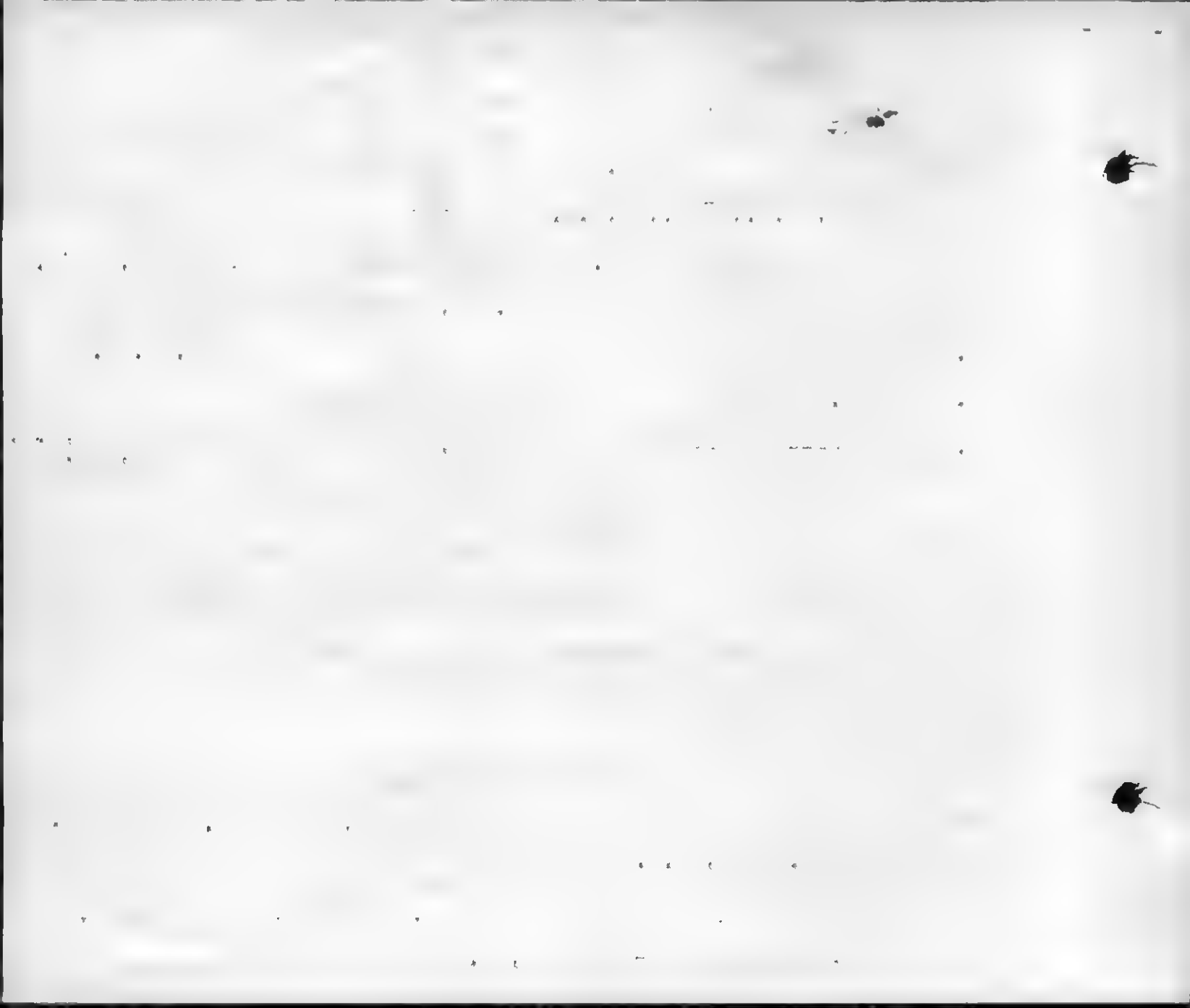
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges'</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ritchie</b>		c. LENGTH OF STAY IN 1b <b>6 Mos.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6808 Ritchie-Marlboro Road, S.E., Wash., D.C.</b>		e. STREET ADDRESS <b>Edgewater</b>	
3. NAME OF DECEASED (Type or print) First <b>Gertrude</b> Middle <b>G.</b> Last <b>Clark</b>		4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>19 58.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 27, 1882</b>
9. AGE (In years last birthday) <b>76 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Elementary School</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Dr. Frank L. Gilbert</b>		14. MOTHER'S MAIDEN NAME <b>Kitturah Dawson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Dudley L. Clark</b>		Address <b>7128 Marlboro Pike, S.E. District Hgts. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442x Congestive heart failure</b> DUE TO (b) <b>Cardiovascular Renal disease</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 9, 19 58</b> to <b>June 23, 19 58</b> that I last saw the deceased alive on <b>June 23, 19 58</b> and that death occurred at <b>9:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Forestville, Maryland.</b> DATE SIGNED <b>6/23/58.</b>			
ACTUAL SIGNATURE <b>James I. Boyd</b> M.D.		PHYSICIAN'S NAME (Type) <b>James I. Boyd, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/28/58:</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cemetery.</b>		22d. LOCATION (City, town, or county) (State) <b>Smyrna, Delaware.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Funeral Home-Marlboro, Md.</b>		ADDRESS <b>Upper</b>	
24a. REC'D BY REGISTRAR <b>DATE JUL 1 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Al. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

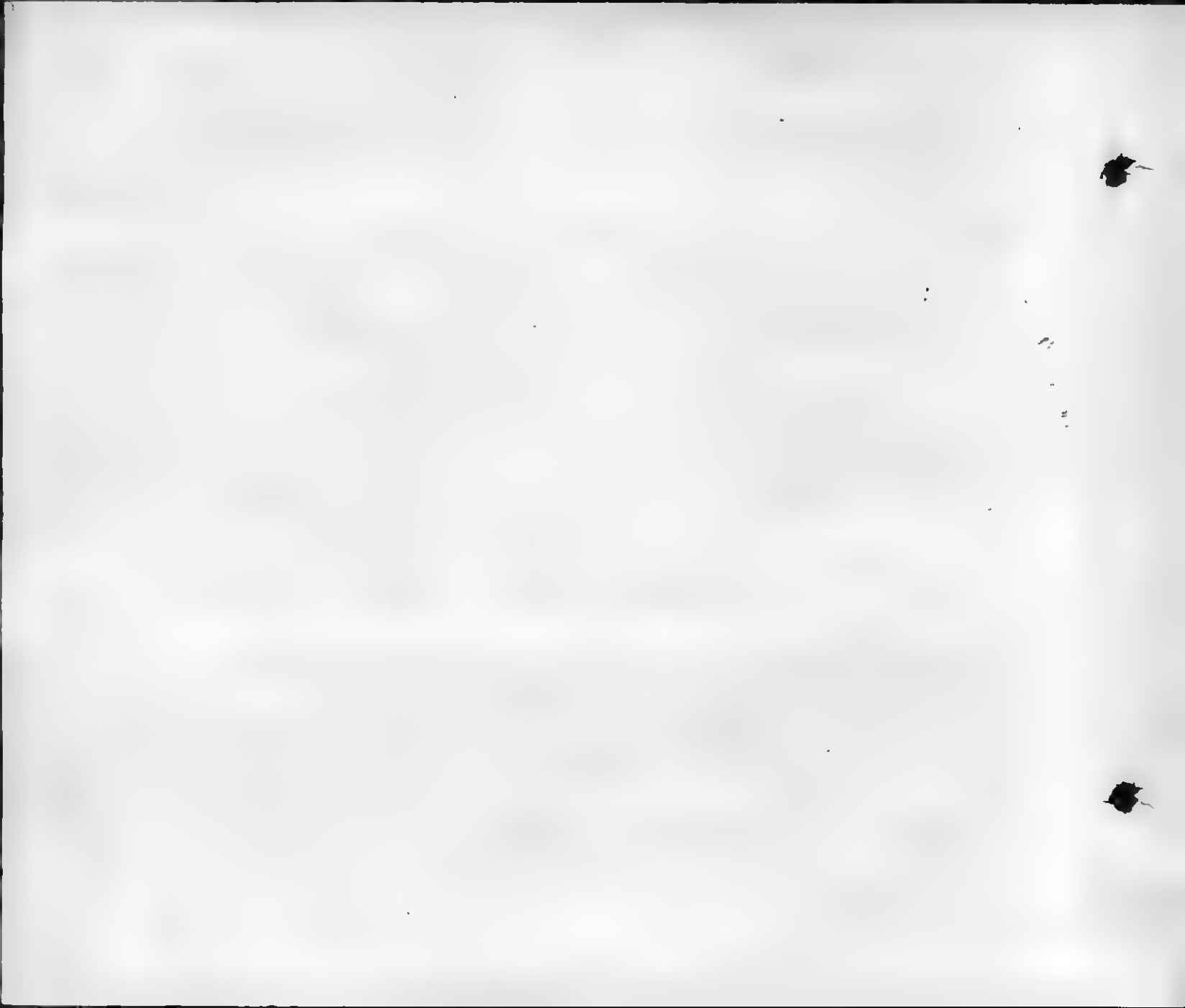
Reg. Dist. No. 07123

7130

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) or INSTITUTION LeLand Memorial Hospital		1d STREET ADDRESS 6026 Mustang Drive	
3. NAME OF DECEASED (Type or print) First Middle Last John Ralph Clarke		4. DATE OF DEATH Month Day Year June 21 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1882
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR: Months 10 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Rufus King Clarke		14. MOTHER'S MAIDEN NAME Nell Greenwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. Chas. Clarke 6026 Mustang Dr Riverdale Md	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Cerebral Thrombosis DUE TO (c) Hypertensive-Cardio-vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 12 June, 1958, to 21 June, 1958, that I last saw the deceased alive on 20 June, 1958, and that death occurred at 9:40 A.M. from the causes and on the date stated above.	
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE: Thos M. Hutchins M.D. 4315 Landover Rd		6-21-58	
PHYSICIAN'S NAME (Type) Thos M. Hutchins		Hyattsville, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	6-24-1958	Washington Natl	Smithland Md
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR
Robert A Mattingly		131-18th St Wash, D.C.	24b. REGISTRAR'S SIGNATURE
		DATE JUN 24 '58	Alberich

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

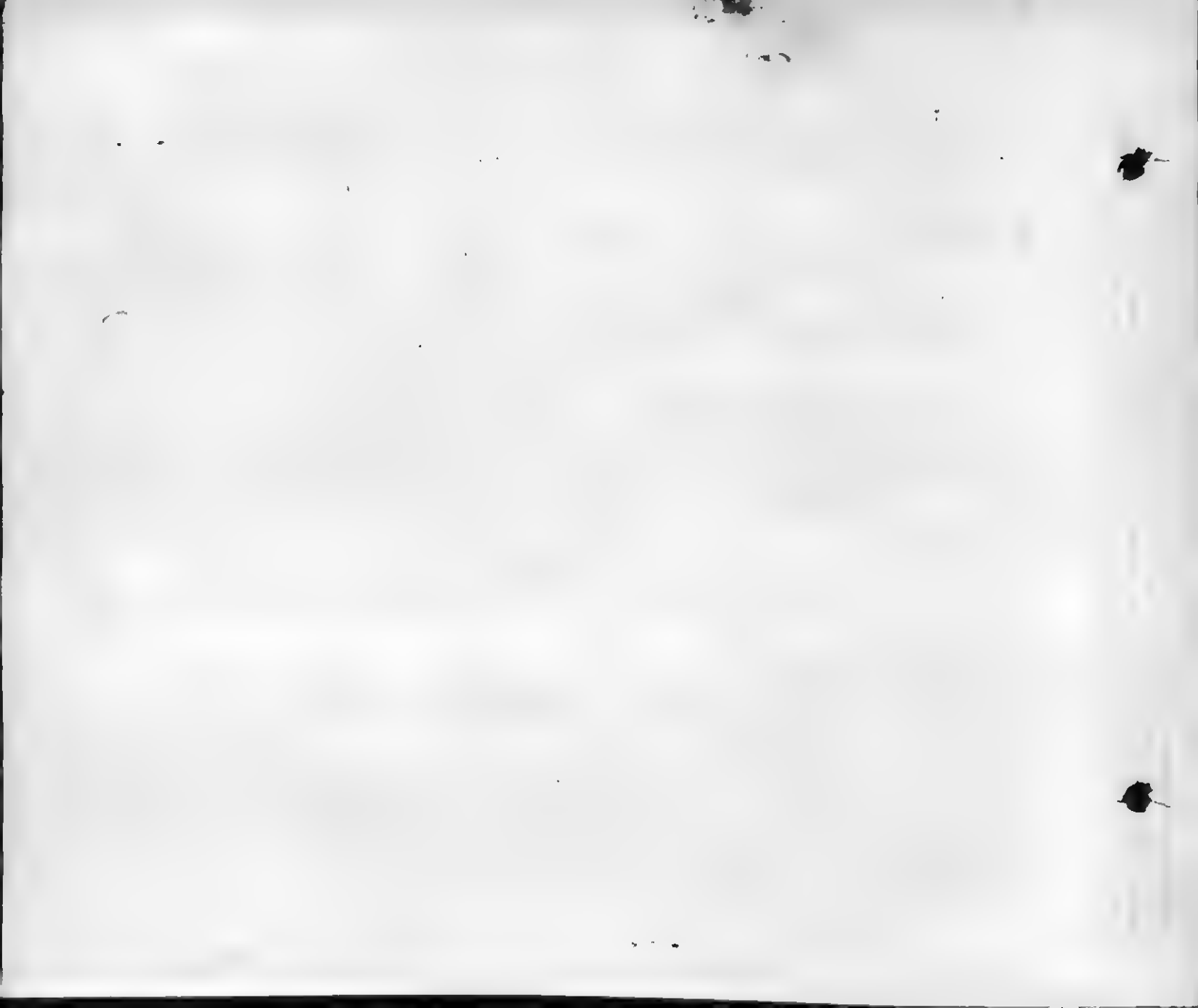


7191  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HIGHLAND PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HIGHLAND PARK</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <b>6902 "M" ST</b>	
3. NAME OF DECEASED (Type or print) <b>ADDIE</b> First Middle Last <b>A. COCKRELL</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>4</b> Year <b>1958</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>N.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 1, 1888</b> 69
9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PREACHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PREACHER</b>	11. BIRTHPLACE (State or foreign country) <b>ALABAMA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>JACKSON</b>	
14. MOTHER'S MAIDEN NAME <b>?</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT ( <b>HUSBAND</b> ) <b>ASBURY COCKRELL</b> Address <b>6902 "M" ST.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>25X</b> DUE TO (b) <b>PNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <b>LUES (CNS)</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>4 DAYS</b> <b>2 YEARS?</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>SEPT. 1956</b> to <b>JUNE 1958</b> , that I last saw the deceased alive on <b>JUNE 4, 1958</b> and that death occurred at <b>4:00 P.M.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Ernest W. Underhill</b>		ADDRESS (Street, city or town, state) <b>2220 BOOKER DR. HUNTSVILLE AL.</b> DATE SIGNED	
NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-7-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woadman</b>	22d. LOCATION (City, town, or county) (State) <b>Wash DC</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Bacon</b> ADDRESS <b>1722 78th St</b>		24a. REC'D BY REGISTRAR <b>DATE</b>	24b. REGISTRAR'S SIGNATURE <b>DATE</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7131 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

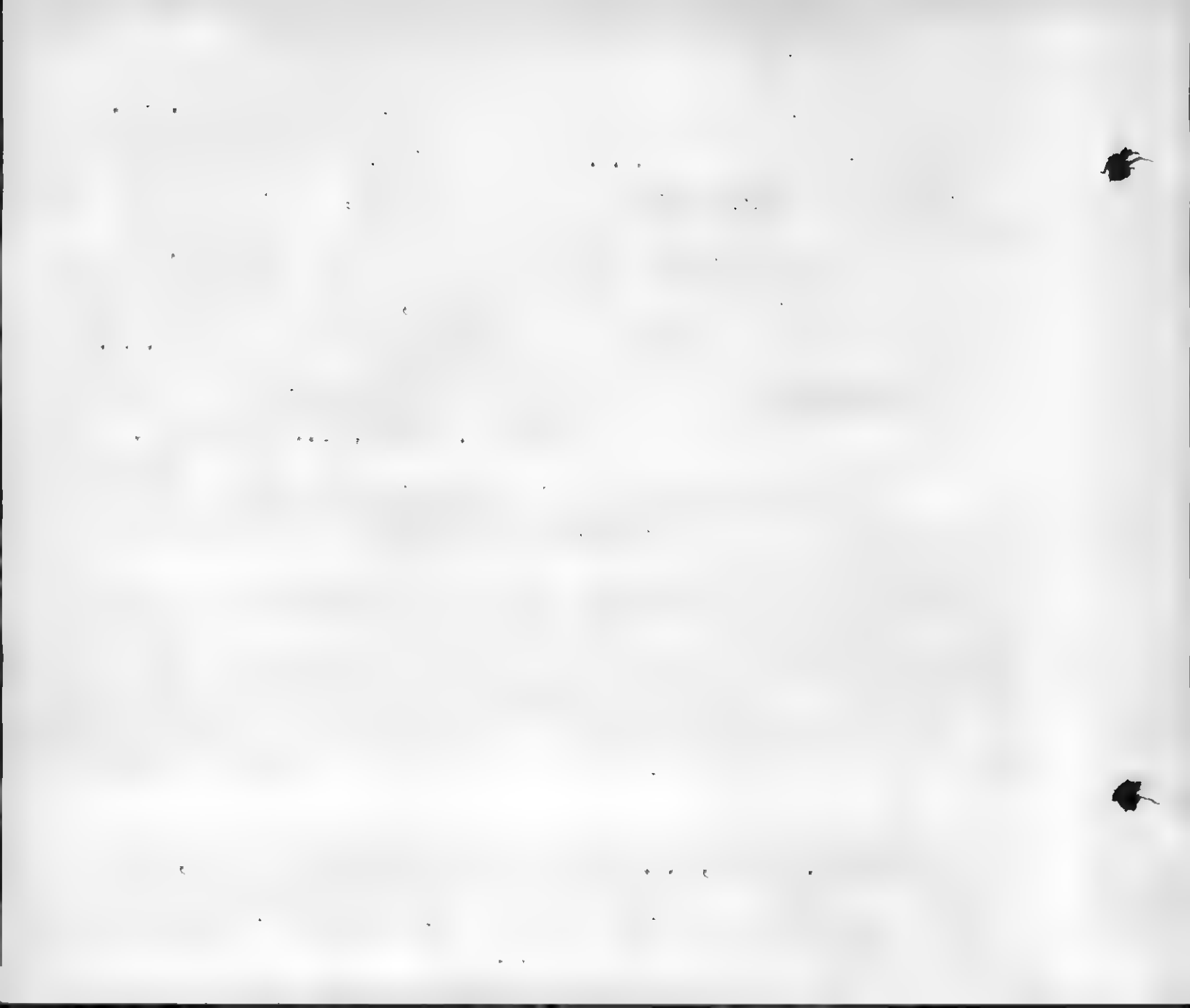
07125

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please  
execute the cert. by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page  
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellville</b>	
f. STREET ADDRESS <b>Route 2, Box 139</b>		g. IS DECEASED ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Edward</b> Last <b>Coleman</b>		4. DATE OF DEATH Month <b>June</b> Day <b>12,</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 4, 1889</b>
9. AGE (in years last birthday) <b>69 yrs.</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>9</b> Hours <b>12</b> M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Coleman</b>		14. MOTHER'S MAIDEN NAME <b>Hester Shephard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>James E. Coleman, Jr., Same address.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular renal disease</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>June</b> Day <b>12</b> Year <b>1958</b> Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>June 12, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/17/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Nebo Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Queen Anne District Prince Geo. County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John S. Stewart</b>		24a. REC'D BY REGISTRAR <b>JUN 16 1958</b>	
ADDRESS <b>30 H Street, N.E.</b>		24b. REGISTRAR'S SIGNATURE <b>John S. Stewart</b>	





7192

Item 14 Film 230 6-26-58 et

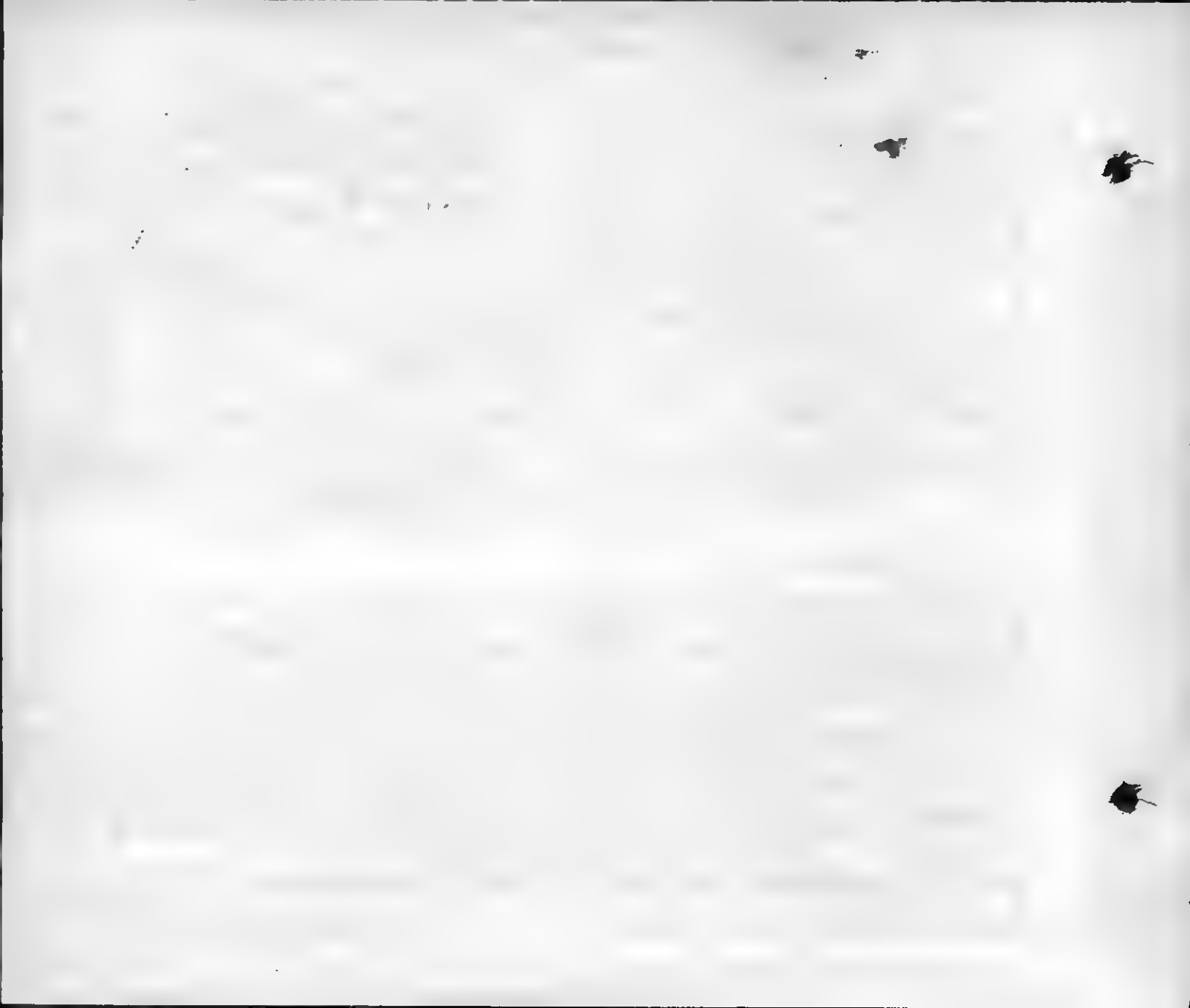
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thilade</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thilade, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1111-57 Ave Thilade Md</u>		d. STREET ADDRESS <u>1111-57 Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLOTTE E. CONRAD</u>		4. DATE OF DEATH Month <u>6</u> Day <u>18</u> Year <u>1958</u>	
5 SEX <u>7</u>	6. COLOR OR RACE <u>72</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 4 - 1880</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>HENRY SMITH</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type, no. or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>John R. Conrad - 1111-57 Ave. Thilade</u>	
17. INFORMANT Address <u>Thilade</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Arteriosclerosis Generalized</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema Pulmonary, Pulmonary Fibrosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 Dec 1957</u> to <u>18 June 1958</u> that I last saw the deceased alive on <u>4 June 1958</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Thomas P. Fogarty</u> M.D. <u>104 University Blvd E. New Windsor</u>		PHYSICIAN'S NAME (Type) <u>THOMAS P. FOGARTY</u> <u>18 June 58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-21-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Thilade Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Regina Walsh - 741-11th St. N.E. Wash. D.C.</u>		24a. RECEIVED BY REGISTRAR DATE <u>JUN 20 1958</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7112

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>2mo.18 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>L.</u> Last <u>Counts Sr.</u>		4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18, 1860</u>
9. AGE (In years last birthday) yrs. <u>98</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elijah Shelby Counts</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Rasnick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>579-24-5180A</u>	
17. INFORMANT <u>Richard L. Counts Jr.</u>		Address <u>Bethesda, Md.</u> <u>905 Redwood Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SHOCK</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PNEUMONIA</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 HOURS</u> <u>3 DAYS</u> <u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>11-2</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1958</u> , to <u>20 JUN 1958</u> , that I last saw the deceased alive on <u>20 JUN 1958</u> , and that death occurred at <u>2:55 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry R. Wolfe</u>		ADDRESS (Street, city or town, state) <u>905 SHERIDAN ST. HYATTSVILLE</u>	
PHYSICIAN'S NAME (Type) <u>Henry R. Wolfe</u>		DATE SIGNED <u>6/20/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-23-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>
22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u>		24. REC'D BY REGISTRAR (Signature) <u>John J. Smith</u>	
ADDRESS <u>3821-14th St. N.W.</u>		DATE <u>JUN 23 '58</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

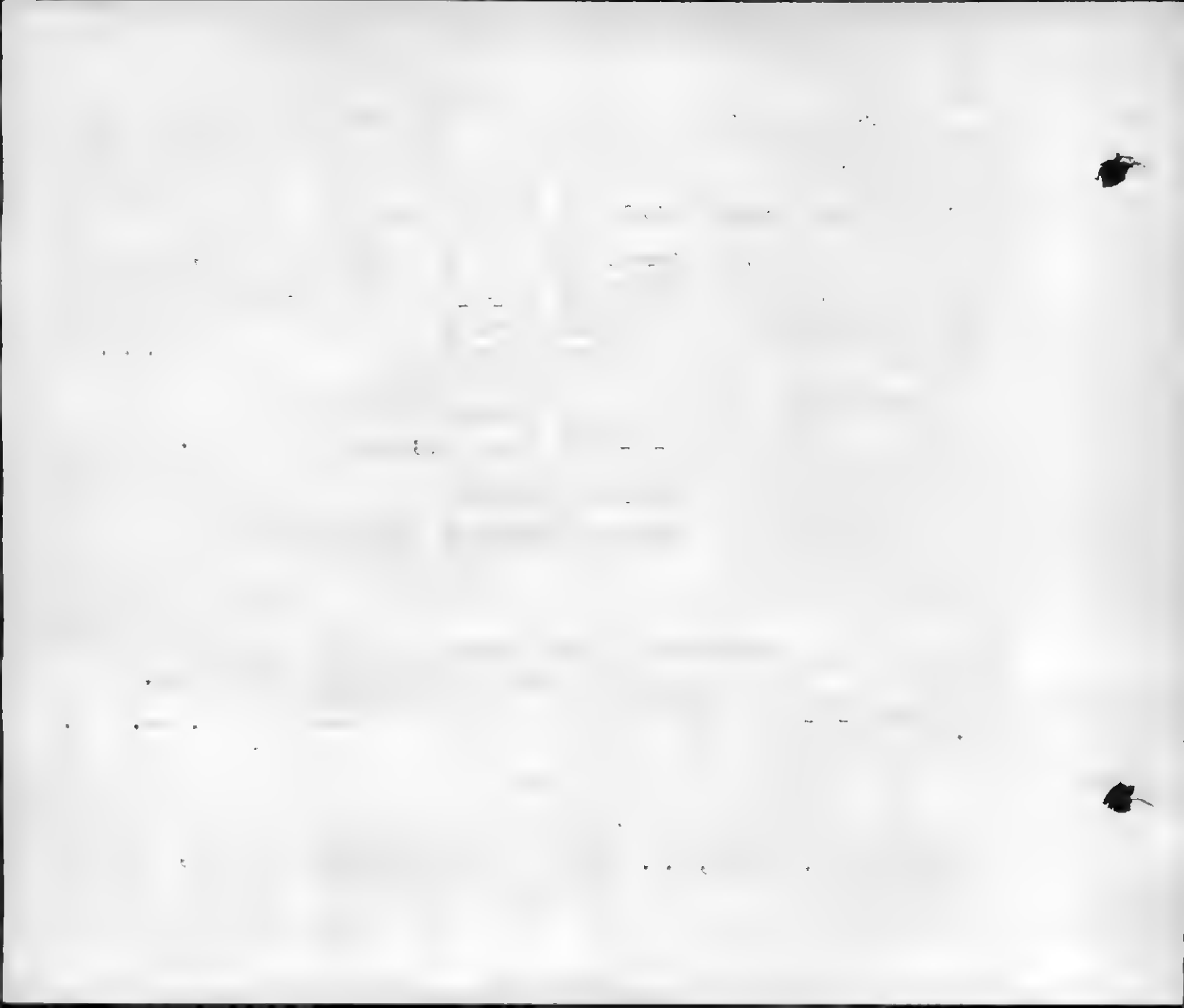
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7132 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07128

Reg. Disf. No.

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>6715 Gary Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Robert</b> <b>Garyton</b> <b>Day</b>		4. DATE OF DEATH <b>June 15, 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-19-40</b>
9. AGE (In years last birthday) <b>17</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stock clerk</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Gordon Warfield Day</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Zellers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>220-36-1395</b>	
17. INFORMANT <b>Gordon Day; same address as #2.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b>			
DUE TO (b) <b>Compound, comminuted fracture of skull</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Passenger in an automobile in collision with another.</b>	
20c. TIME OF INJURY Month, Day, Year <b>4:00 p.m. 6-14-58</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>	20f. (City or town) <b>Cheverly</b> (County) <b>Pr. Geo.</b> (State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>June 15, 1958</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 19, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	22d. LOCATION (City, town, or county) <b>Colgate, Md.</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home 2112 Dundalk Ave.</b>		24a. REC'D BY REGISTRAR <b>JUN 18 '58</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MS A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7193 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07129

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>	
c. LENGTH OF STAY IN 1b <u>Head on arrival</u>		d. STREET ADDRESS <u>Rt #2 Box 38</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Her. Johnsons Office</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Phillip Herizo Perry Jr</u>	First Middle Last	4. DATE OF DEATH <u>June 12 1958</u>	Month Day Year
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Sept 7, 1954</u>
	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years, last birthday) <u>3</u> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>District of Columbia D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Phillip Herizo Perry Sr</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Bernadine Russek</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mary B McCell, same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		DATE SIGNED <u>June 13, 1958</u>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-17-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin Bros.</u>		24a. REC'D BY REGISTRAR <u>1661- Wood Hope Rd St. Wash DC</u>	24b. REGISTRAR'S SIGNATURE <u>Ed. J. Egan</u>

DATE JUN 16 '58





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7133 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07130

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chenery</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Switzland</u>	
c. LENGTH OF STAY IN 1b <u>Switzland</u>		d. STREET ADDRESS <u>4733 Homer Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clara May Kelley</u>		4. DATE OF DEATH <u>June 13 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4 1887</u>
9. AGE <u>71</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Gun Home</u>	11. BIRTHPLACE (State or foreign country) <u>Minnesota</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Frank Festler</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Hamming</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or not known) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Walter Kelley same as #1</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>904.0 Pulmonary embolism</u> DUE TO (b) <u>Fracture of left forearm</u> DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell in home and fractured forearm</u>	
20c. TIME OF INJURY Month, Day, Year <u>June 5 1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. CITY OR TOWN (County) (State) <u>Switzland P. G. Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>June 13, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/16/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Switzland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Inc. Jt.</u>		24a. REC'D BY REGISTRAR <u>June 16 '58</u>	
ADDRESS <u>317 P. Ave., S. E</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



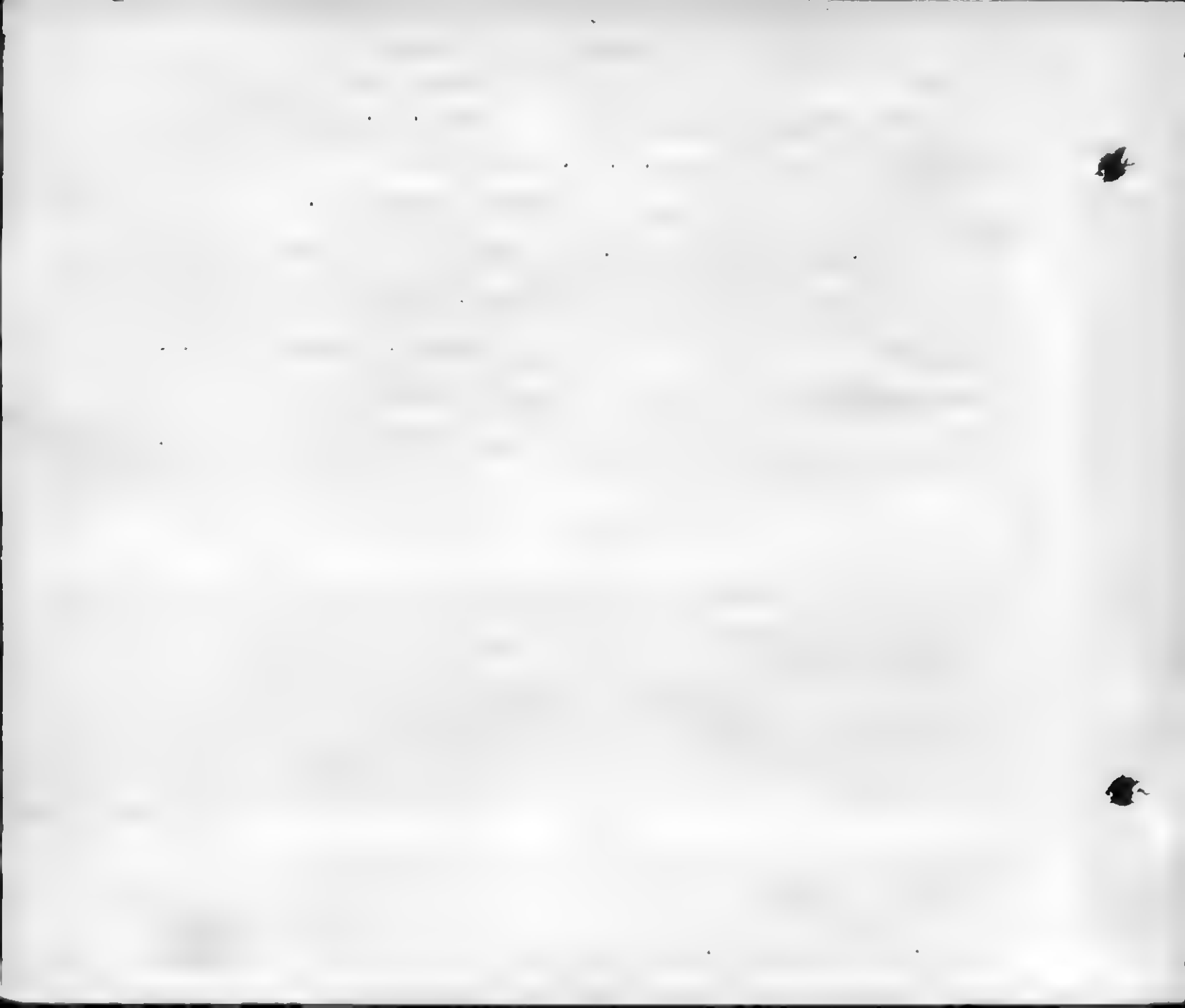
7113

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Baltimore, Md.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Maryland</b>				c. LENGTH OF STAY IN 1b <b>4 mo. 3 wks.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mrs. Elizabeth A. Doehler</b>				4. DATE OF DEATH Month Day Year <b>June 30 19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 8, 1870</b>	
9. AGE (In years last birthday) <b>87</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Engelhardt</b>				14. MOTHER'S MAIDEN NAME <b>Anna Yeakel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT Address <b>Sister Hyacinth, Sacred Heart Home, Hyattsville Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, lobar, both lungs</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Feb. 6</b> , 19 <b>58</b> to <b>June 30</b> , 19 <b>58</b> that I last saw the deceased alive on <b>June 30</b> , 19 <b>58</b> , and that death occurred at <b>4:05 P.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>332 H St NE Washington DC</b> DATE SIGNED <b>6/30/58</b>							
ACTUAL SIGNATURE <b>Thomas F Collins</b> M.D.				PHYSICIAN'S NAME (Type) <b>Thomas F Collins</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/3/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery Baltimore, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran -3000 E. Baltimore Street</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7194

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill (Rural)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6745 Prince George Drive S.E.				d. STREET ADDRESS 6745 Prince George Drive			
3. NAME OF DECEASED (Type or print) First Middle Last Mande Irene Donaldson				4. DATE OF DEATH Month Day Year June 28 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 7, 1891	
9. AGE (In years last birthday) 62 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Saleslady		11. BIRTHPLACE (State or foreign country) Lorton, Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Frank C. Clark				14. MOTHER'S MAIDEN NAME Marietta Burdette			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. 514-22-2740			
17. INFORMANT Address Alma Woodlief 732 Burrhead Rd. Falls Church, Va.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)].							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia							
DUE TO (b) Arterio-Sclerotic Heart Disease							
DUE TO (c) Diabetes Mellitus							
DUE TO (c) Coronary Thrombosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic Cataracts							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 1955 to 6-28-1958 that I last saw the deceased alive on 6-27-1958, and that death occurred at 4:40 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Anna Coyne Todd M.D. 7519 Broadview Rd. S.E. 8/28/58							
PHYSICIAN'S NAME (Type) Anna Coyne Todd D.C. 22							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7-1-1958		22c. NAME OF CEMETERY OR CREMATORY Glenwood		22d. LOCATION (City, town, or county) (State) Wash., D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 131-11 24th St. Wash., D.C.							
24a. REC'D BY REGISTRAR DATE JUN 30 '58							
24b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7195

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>District Heights</i> <i>STEVENSVILLE</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>District Heights</i> <i>M.D.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5814 Ritchie Rd</i>		d. STREET ADDRESS <i>5814 Ritchie Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>Amelia</i> First Middle Last		4. DATE OF DEATH <i>June 12 1958</i> Month Day Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 9, 1888</i> AGE (in years last birthday) <i>77</i> yrs.
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>		10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>England</i>
13. FATHER'S NAME <i>John T. Askey</i>		14. MOTHER'S MAIDEN NAME <i>Phoebe Flowers</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <i>No</i>	17. INFORMANT Address <i>Amelia P. Dickson - 5814 Ritchie Rd.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Heart Disease</i> DUE TO <i>Myocardial Insufficiency</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO <i>Arteriosclerosis</i> (c) <i>Arteriosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4. Min.</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>5. 77 - Kidney disease</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 1</i> , 19 <i>55</i> , to <i>June 12</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>June 4</i> , 19 <i>58</i> , and that death occurred at <i>1:15</i> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Sidney W. Loucky</i> M.D.		DATE SIGNED <i>June 16 1958</i>	
PHYSICIAN'S NAME (Type) <i>SIDNEY W. LOUCKY M.D. DISTRICT HEIGHTS MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-14-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Bladensburg Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers</i> ADDRESS <i>60 Washington D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 16 '58</i>	24b. REGISTRAR'S SIGNATURE <i>W. W. Chambers</i>

JUN 16 '58

1. HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





7134

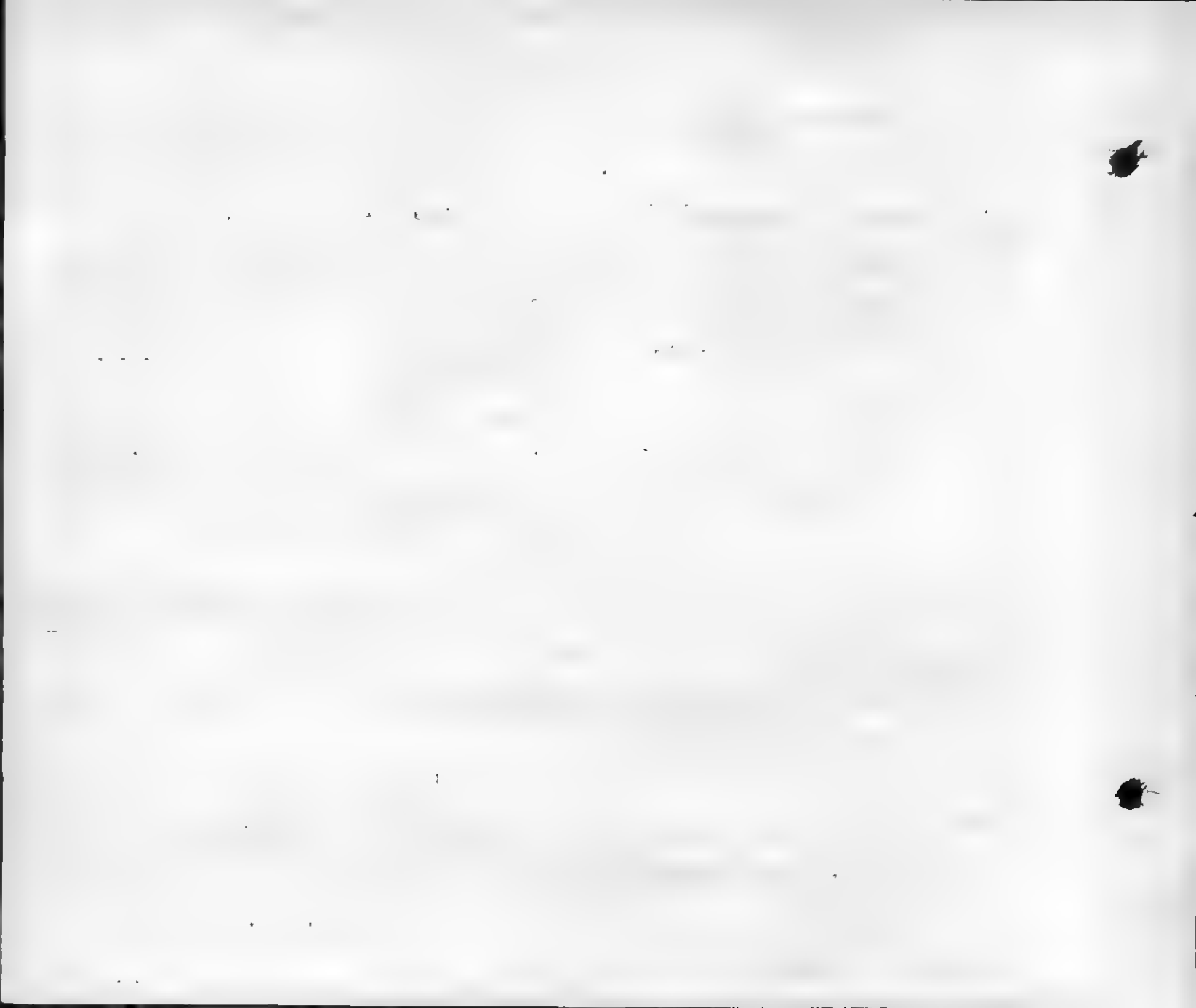
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Cheverly</b>		c. LENGTH OF STAY IN lb <b>3 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Jacob</b>		4. DATE OF DEATH <b>June 19 1958</b>	
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>11/11/1878</b>	
9. AGE (In years last birthday) <b>79</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Eurich</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-05-6315</b>	
17. INFORMANT <b>Mrs. Ernestine Garrity</b>		Address <b>Hyattsville 5013 54th. Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs.</b> <b>5 years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 4</b> , 19 <b>52</b> , to <b>June 19</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 19</b> , 19 <b>58</b> , and that death occurred at <b>12:20 P.M.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Charles C. Hageage</b>		DATE SIGNED <b>6/19/58</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Charles Hageage</b>		ADDRESS (Street, city or town, state) <b>3308 Perry St. Mt. Rainier, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>		22b. DATE THEREOF <b>6-23-1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Josephine F. ...</b>		24a. REC'D BY REGISTRAR <b>JUN 24 '58</b>	
ADDRESS <b>7401 Belair Rd</b>		24b. REGISTRAR'S SIGNATURE <b>Willie ...</b>	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**THE FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



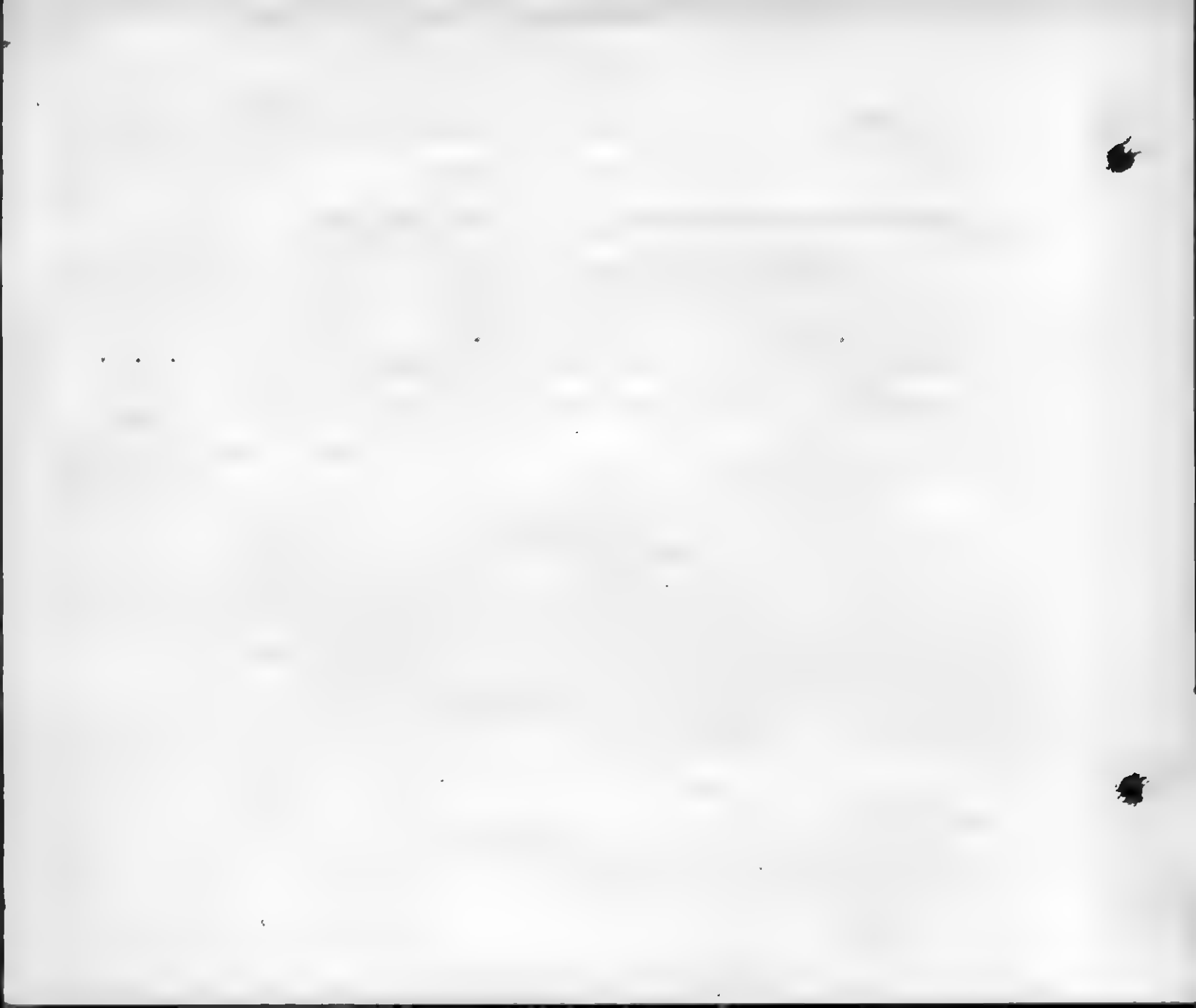
7135

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>10 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Lanham</b> d. STREET ADDRESS <b>7604 Finns Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Catherine Louise Finn</b> First Middle Last		4. DATE OF DEATH <b>June 18 1958</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-13-87</b>
9. AGE (In years last birthday) <b>70</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk - Federal Government Washington, D.C.</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Eugene Hannan</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Drew</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>---</b>	
17. INFORMANT <b>Mary C. Everole</b>		Address <b>above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X</b> <b>Thrombosis</b> DUE TO (b) <b>Thrombosis - Diabetic</b> DUE TO (c) <b>Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>7 mos.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTESTINAL OBSTRUCTION</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 1957</b> to <b>June 1958</b> , that I last saw the deceased alive on <b>18 Jun 1958</b> , and that death occurred at <b>2:20 P.M.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Thomas G. Maloney M.D.</b>		ADDRESS (Street, city or town, state) <b>4814-71st Ave.</b>	
PHYSICIAN'S NAME (Type) <b>THOMAS G. MALONEY MD.</b>		DATE SIGNED <b>18 JUN 58</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/21/1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Malloy's Funeral Home Inc.</b>		ADDRESS <b>Mt. Rainier, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 20 58</b>		24b. REGISTRAR'S SIGNATURE <b>Robert Search</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7136

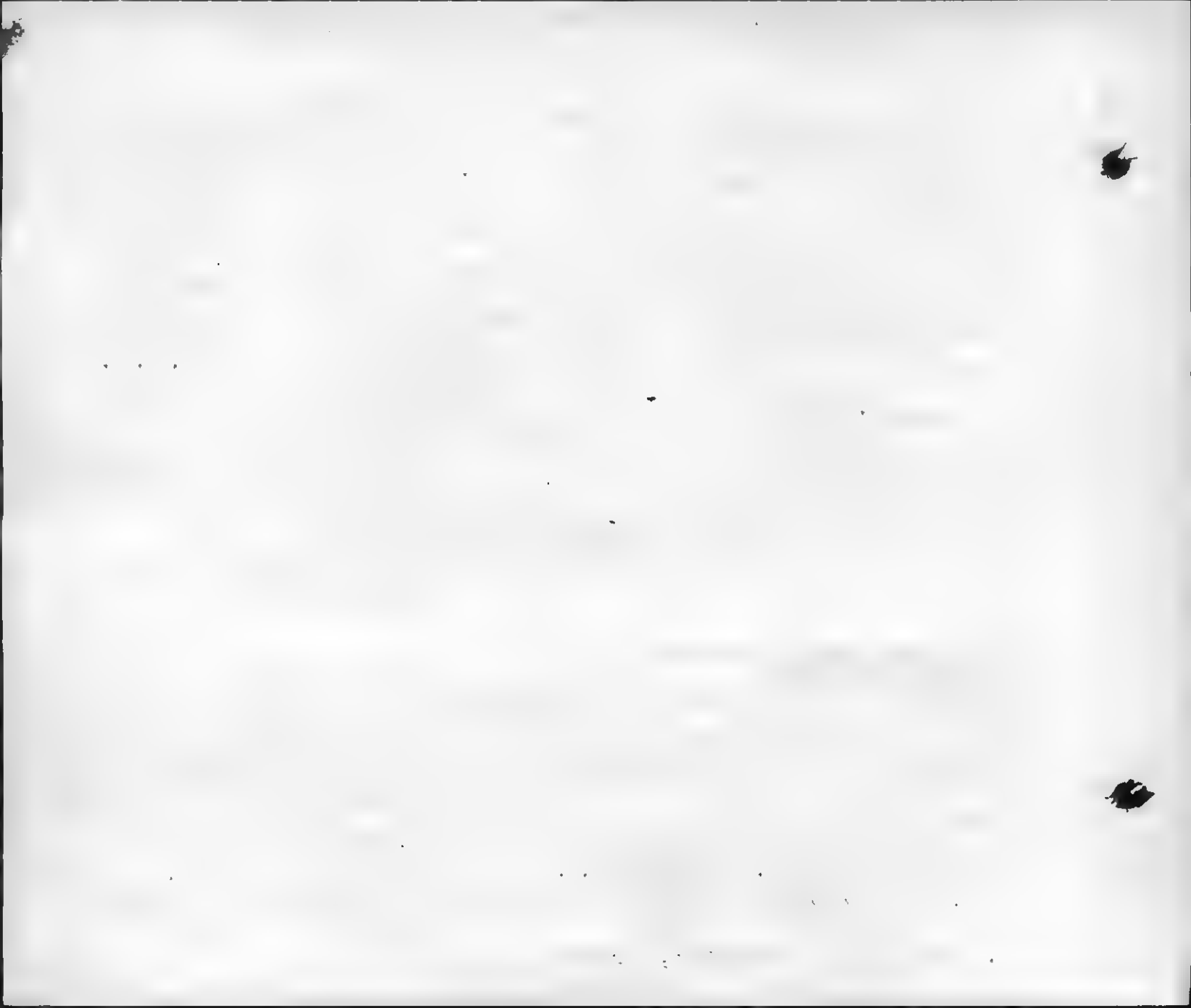
## CERTIFICATE OF DEATH

Reg. Dist. No.

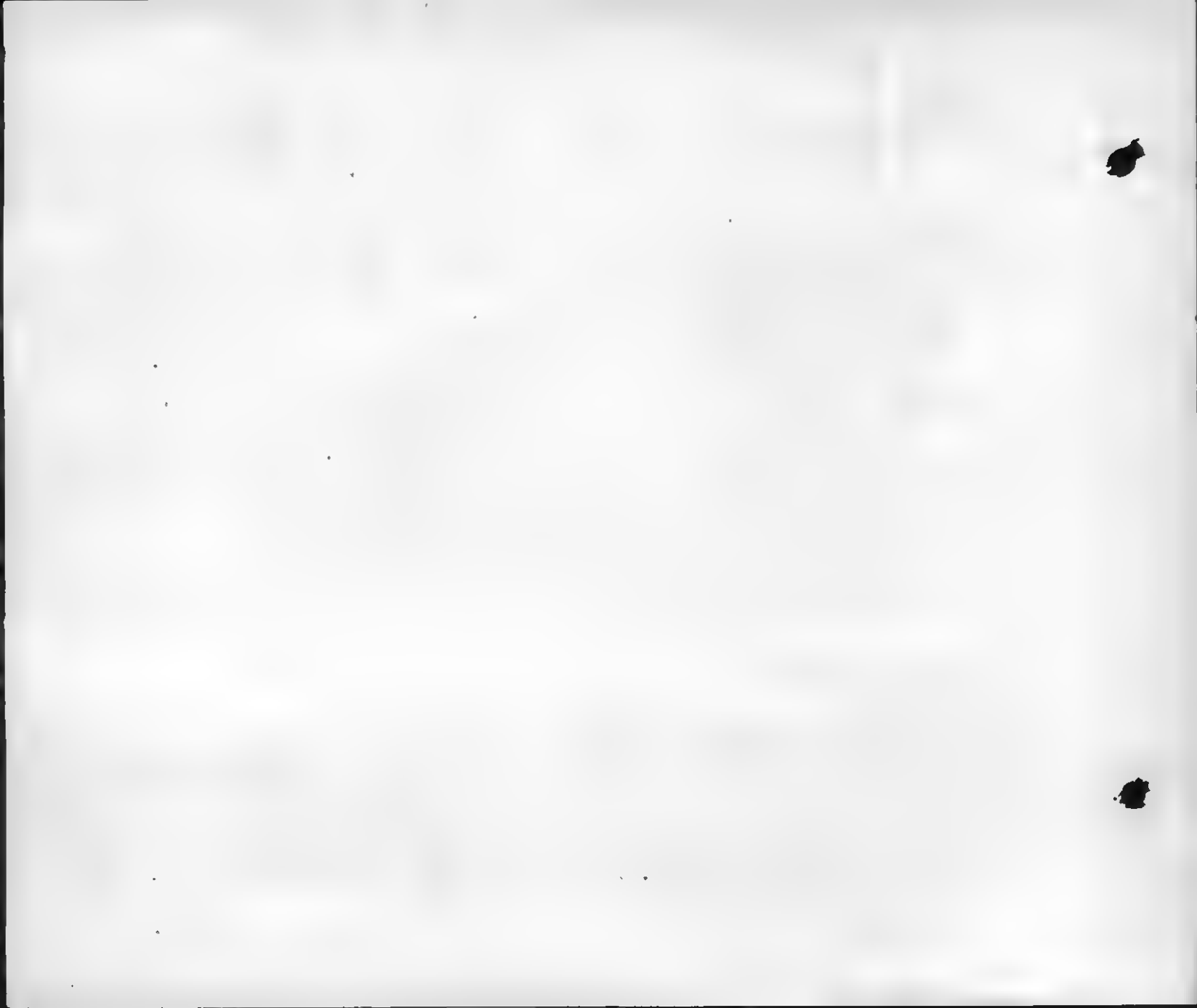
1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>10 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Patricia Marie</b> Middle <b>Flood</b> Last <b>Flood</b>		4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-7-58</b>
9. AGE (In years last birthday) yrs <b>10</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Raymond</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Darrelle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Hospital records Cheverly Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral and pulmonary embolism secondary to thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Placental infarction</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 7, 1958</b> to <b>June 17, 1958</b> that I last saw the deceased alive on <b>June 17, 1958</b> , and that death occurred at <b>3:35 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas A. Christensen M.D.</b>		ADDRESS (Street, city or town, state) <b>College Park, Md.</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Thomas A. Christensen M.D.</b>			
22a. BURIAL CREMATION, etc. (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6/19/1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>George Washington Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hyattsville Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland</b>	
24a. REC'D BY REGISTRAR <b>JUN 23 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.









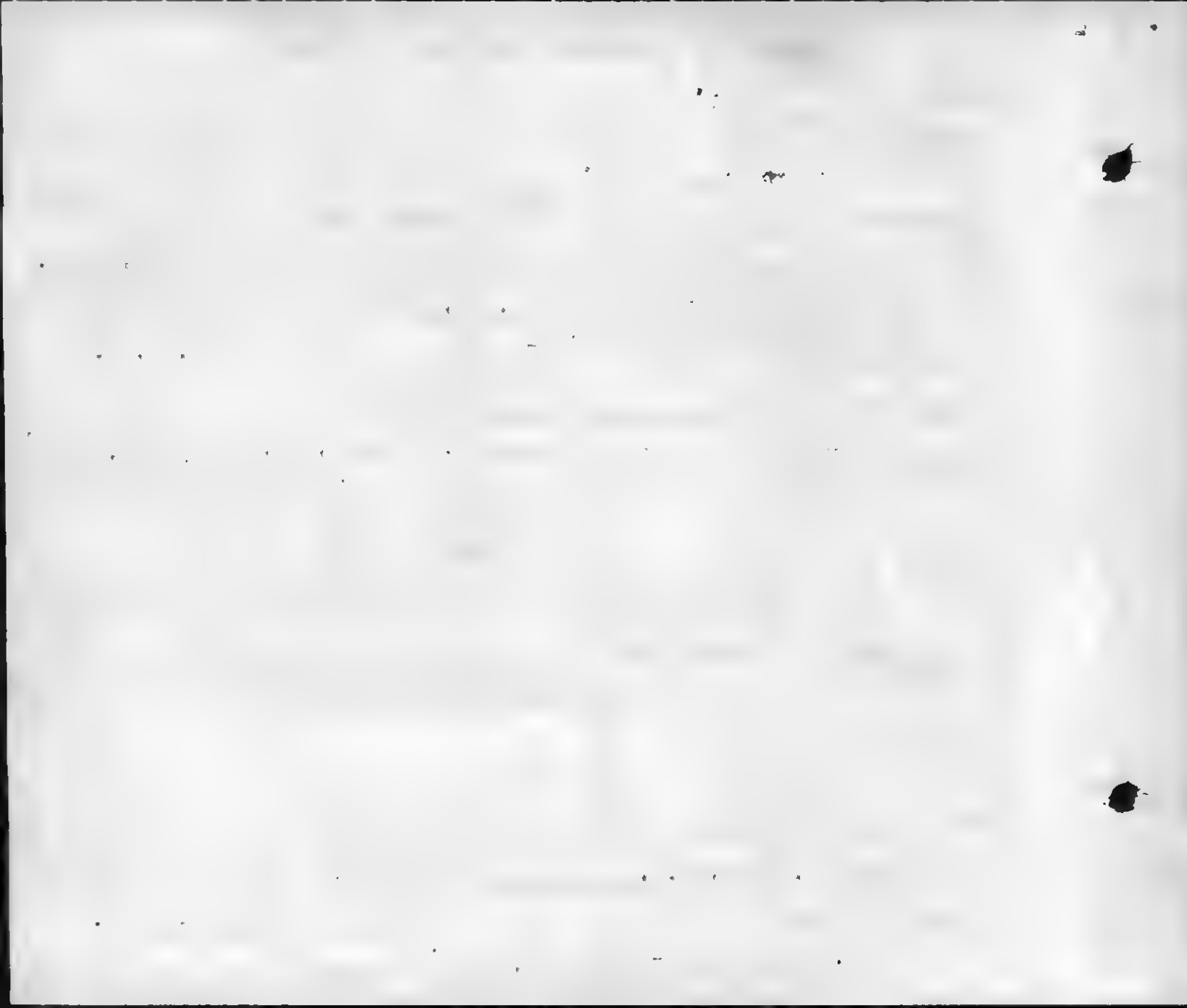
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7198 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07139

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges'</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges'</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>		c. LENGTH OF STAY IN 1b <b>17 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>		d. STREET ADDRESS <b>Largo Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Largo Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Martin</b> Middle <b>Elbert</b> Last <b>Gardner</b>				4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>19 58.</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 19, 1900</b>		9. AGE (In years last birthday) <b>58</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store Proprietor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Produce &amp; Live-Stock</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Ernest Gardner</b>				14. MOTHER'S MAIDEN NAME <b>Cora Needle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>----</b>		17. INFORMANT <b>Martin E. Gardner, Jr.</b> Address <b>Upper Marlboro, Maryland.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO (b) <b>Gun shot wound of head</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self with shot gun</b>					
20c. TIME OF INJURY Month, Day, Year <b>32</b> <b>6-17-58</b> <b>3:00</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Upper Marlboro Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>James I. Boyd, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James I. Boyd, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/20/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Trinity Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Upper Marlboro, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Funeral Home-</b>				ADDRESS <b>Upper Marlboro, Maryland.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 20 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Asst. Sec.</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.



7138

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly Md</b>		c. LENGTH OF STAY IN 1b <b>33 4203 53rd ave</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>Bladensburg, Md.</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>E.</b> Last <b>Gasson</b>		4. DATE OF DEATH Month <b>June</b> Day <b>29</b> , Year <b>58-</b> 19	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 20, 1883</b>
9. AGE (In years and birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Washington Gas Company</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington D. C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Henry J. Gasson</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Swann</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>William C. De Neane</b>		Address <b>Silver Springs, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Heart Disease</b> DUE TO (c) <b>Complete Heart Block</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 19, 1946</b> to <b>June 27, 1958</b> that I last saw the deceased alive on <b>June 27, 1958</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>6304 Annapolis Rd G 2755</b>			
ACTUAL SIGNATURE <b>Dayton O Watkins</b> M.D.		PHYSICIAN'S NAME (Type) <b>DAYTON O WATKINS Bladensburg Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 2, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 2 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7139

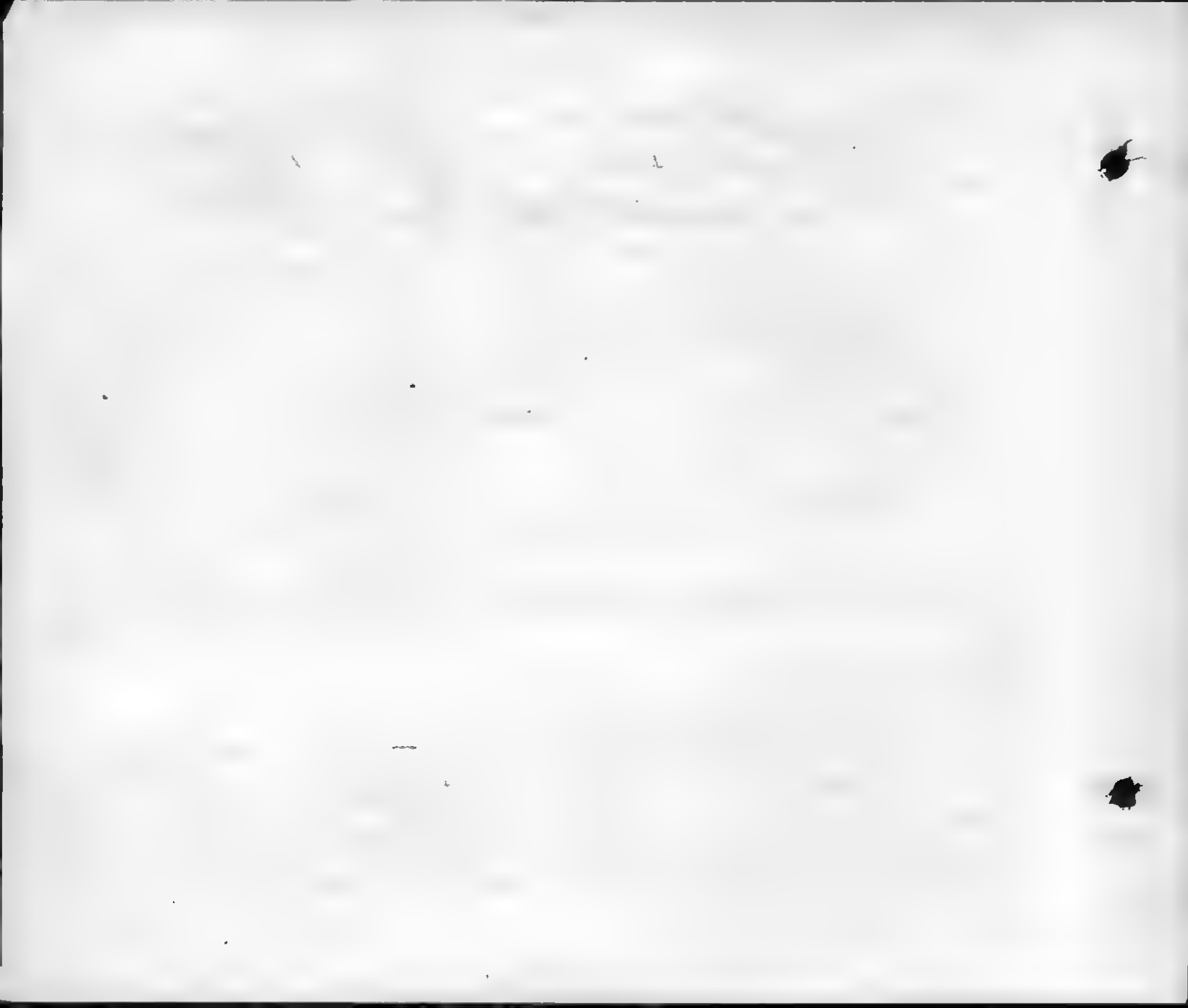
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md b. COUNTY P.D.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNIV. PK.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince Georges Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gladys E. Gervais		4. DATE OF DEATH June 8 1958	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1893
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired employ. U.S. Govt.		11. BIRTHPLACE (State or foreign country) Dawsonville, Ga.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Peter J. Stang	
14. MOTHER'S MAIDEN NAME Olive A. Hoffman		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <input type="checkbox"/>	
16. SOCIAL SECURITY NO		17. INFORMANT Lorraine E. Babcock	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arterio-sclerotic Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 10, 1949, to June 8, 1958, that I last saw the deceased alive on June 8, 1958, and that death occurred at 4:03 pm, from the causes and on the date stated above.			
ACTUAL SIGNATURE C. C. Hageage		DATE SIGNED M.D. 3308 Perry St., Mt. Rainier, Md. 6/	
PHYSICIAN'S NAME (Type) C. C. Hageage M.D.		3308 Perry St. Mt. Rainier, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/12/58	
22c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery		22d. LOCATION (City, town, or county) (State) Bristol, Conn.	
23. FUNERAL DIRECTOR'S SIGNATURE Halley Funeral Home		24b. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
ADDRESS 3200 N. 4th St. Baltimore, Md.		DATE JUN 11 1958	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7114

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville Maryland</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll Manor Rest Home</b>		e. STREET ADDRESS <b>507 Washington St.,</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Glick</b>		4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>1958</b>	
5 SEX <b>female</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 23, 1898</b>
9 AGE (In years last birthday) yrs <b>59</b>		IF UNDER 1 YEAR Months <b>59</b> Days <b>11</b> Hours <b>11</b> Min <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11 BIRTHPLACE (State or foreign country) <b>Frostburg, Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
13. FATHER'S NAME <b>Daniel F. McMullen</b>		14. MOTHER'S MAIDEN NAME <b>Anna McNamee</b>	
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16 SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Mrs. John H. Glick 308 Washington St., Cumb. Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>331 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 10, 1958</b> to <b>June 16, 1958</b> , that I last saw the deceased alive on <b>June 10, 1958</b> , and that death occurred at <b>5:40 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>William T. Saccardi M.D.</b>			
PHYSICIAN'S NAME (Type) <b>WILLIAM T. SACCARDI 1150 Conn. Ave Wash DC</b>			
22a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/14/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>S. S. Peter &amp; Paul's</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 16 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. S. Saccardi</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7140

CERTIFICATE OF DEATH

07143

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edenburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bide-a-bury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>15212 Tilden Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>E.</u> Last <u>GRADY</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 19 1951</u>
9. AGE (In years last birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor R.R. Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Orange Va</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>John E. Grady</u>		14. MOTHER'S MAIDEN NAME <u>Helen Faubrey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>no</u>	
17. INFORMANT <u>Clary K. Grady 5212 Tilden Rd</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MAY 31, 1958</u> , to <u>JUNE 6, 1958</u> , that I last saw the deceased alive on <u>JUNE 6, 1958</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William D. Ross</u>		ADDRESS (Street, city or town, state) <u>5304 Annapolis Rd, Bladensburg, Md.</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM D. ROSS</u>		DATE SIGNED <u>MARYLAND</u>	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>June 9, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Shirwood</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. ...</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 11 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07144

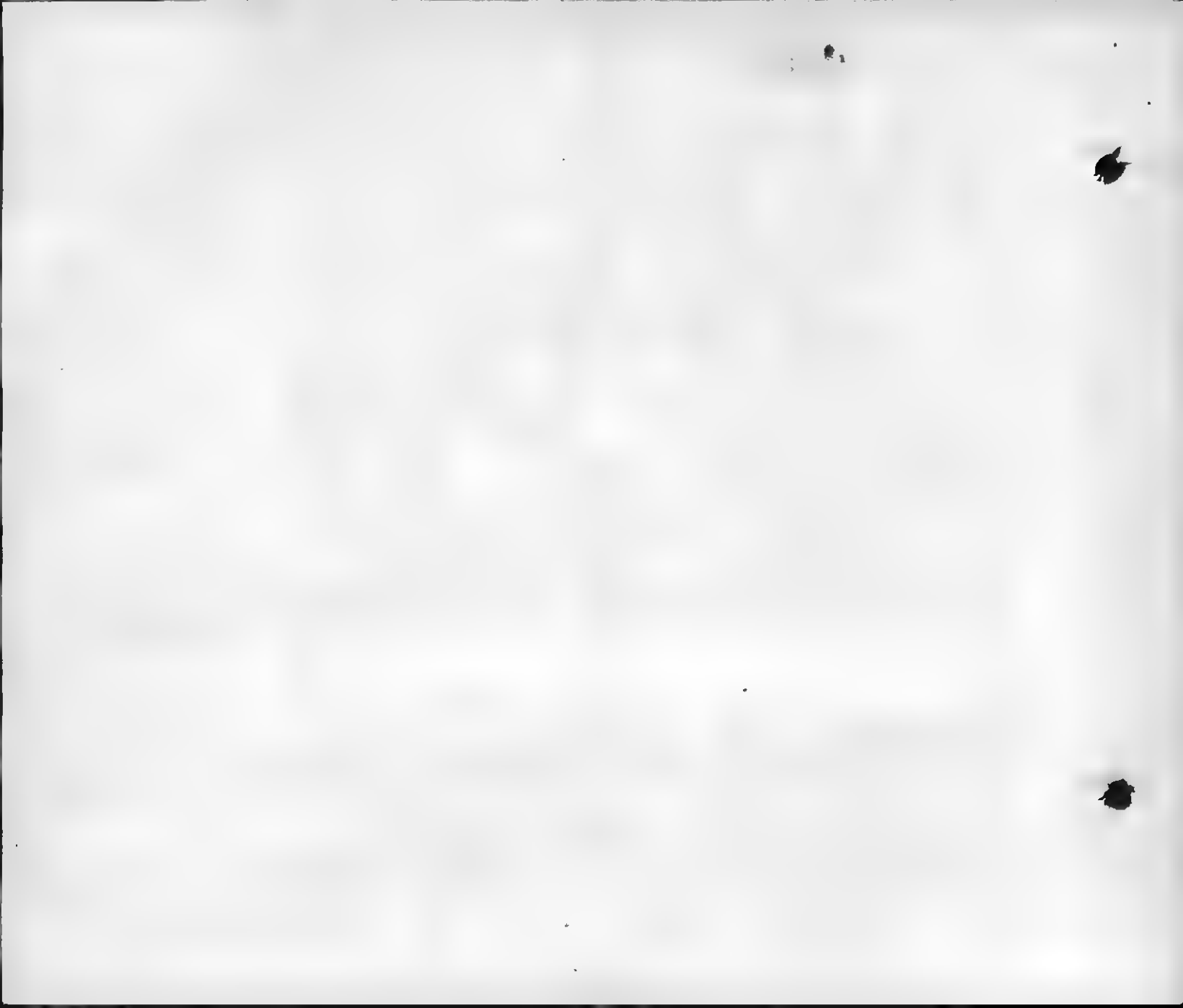
7197

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please secure the cert. for "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Heer Park Heights</u>		c. LENGTH OF STAY IN 1b <u>1 year</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Heer Park Heights</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2219 Beaumont Heights</u>				d. STREET ADDRESS <u>2219 Beaumont Heights</u>			
3. NAME OF DECEASED (Type or print) <u>James Gary Gregory</u>				4. DATE OF DEATH <u>June 16 1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28, 1946</u>	9. AGE (In years last birthday) <u>11</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>	IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>West of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William L Gregory</u>				14. MOTHER'S MAIDEN NAME <u>Mildred G. Holmes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>William L Gregory, same as</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation</u>							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Being trapped in a cedar chest</u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Trapped in a cedar chest</u>					
20c. TIME OF INJURY Month, Day, Year <u>6-16 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Heer Park Heights P.G. Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u>				24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	
ADDRESS <u>517 11th St SE</u>				DATE <u>JUN 19 58</u>		<u>  </u>	



7198

CERTIFICATE OF DEATH

Reg. Dist. No. 07145

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 41X	
c. LENGTH OF STAY IN 1b 2 months and 17 days		d. STREET ADDRESS 634 Que St., N. W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles E. Grimes		4. DATE OF DEATH Month 6 Day 5 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/22/22
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Messenger Clerk		10b. KIND OF BUSINESS OR INDUSTRY Veterans Administration Va.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paul Grimes		14. MOTHER'S MAIDEN NAME Mary Fitzhugh Grimes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 142 - 1943 579-14-7564	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post-operative hemorrhage DUE TO Right upper lobectomy and removal of superior segment of right lower lobe. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary tuberculosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 days 6/3/58 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/19, 1958, to 6/5, 1958, that I last saw the deceased alive on 6/5/58, and that death occurred at 2:55 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE H. E. Weir		DATE SIGNED 6/5/58	
PHYSICIAN'S NAME (Type) Glenn Dale, Md.		ADDRESS (Street, city or town, state) Glenn Dale Hospital	
22a. DATE OF REMOVAL (Specify)	22b. DATE THEREOF 6/5/58	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) Washington D.C.
23. FUNERAL DIRECTOR'S SIGNATURE W. Ernest Janis Jr. 11432 Grosvenor St. N.W.		24a. REC'D BY REGISTRAR DATE JUN 9 '58	24b. REGISTRAR'S SIGNATURE



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

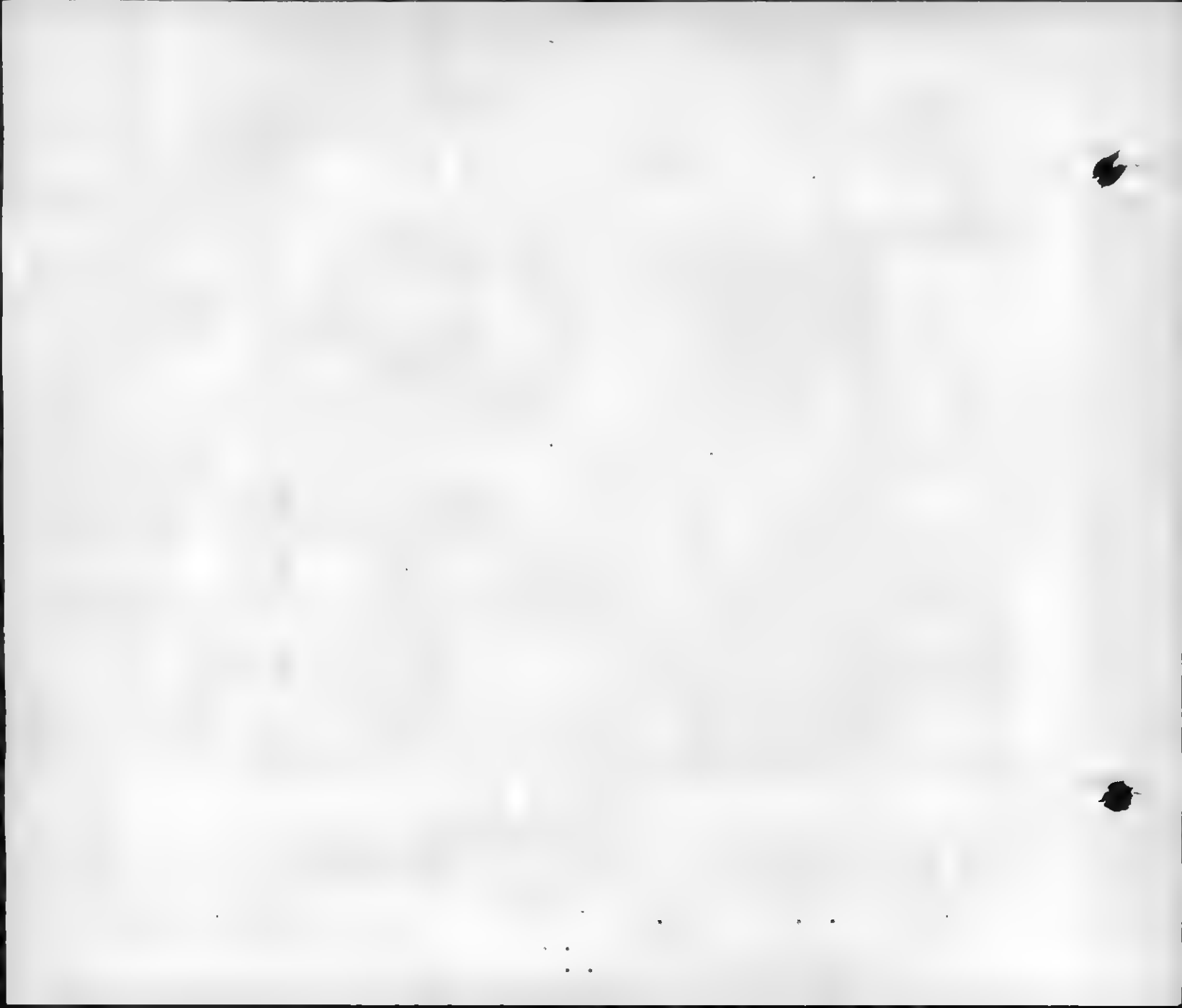
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EM 2-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7141 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07146

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If initial or Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>	
c. LENGTH OF STAY IN 1b <u>Headmaster</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Sylvester Harrison</u>	4. DATE OF DEATH <u>June 20 1958</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 27, 1904</u>
9. AGE (in years last birthday) <u>53</u> yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.-C</u>
13. FATHER'S NAME <u>Norman Harrison</u>	14. MOTHER'S MAIDEN NAME <u>Mary</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>220-16875</u>	17. INFORMANT <u>Edna Harrison, same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u>			
DUE TO (b) <u>Carcinoma of stomach</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>June 20, 1958</u>
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6.23.58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. McGuire</u>		24a. REC'D BY REGISTRAR <u>June 25 58</u>	
ADDRESS <u>1820 9th St., N.W. Washington, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Book of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7142 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07147

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leesville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen. Hosp.</u>			e. STREET ADDRESS <u>Defense Highway</u>		
3. NAME OF DECEASED (Type or print) <u>Dahm Wayne Hebron</u>			4. DATE OF DEATH Month <u>June</u> - Day <u>10</u> - Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-22-58</u>		9. AGE (In years last birthday) yrs <u>2</u> Months <u>2</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
13. FATHER'S NAME <u>Dahm W. Hebron</u>			14. MOTHER'S MAIDEN NAME <u>Helma Chase</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Helma Chase, same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>441X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John T. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>June 10 1958</u>	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-20-58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>	
22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry L. Washington</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 13 '58</u>	
ADDRESS <u>461 West N.W.</u>		24b. REGISTRAR'S SIGNATURE <u>Al. Leach</u>			

MEDICAL CERTIFICATION

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7143

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Laurel, Maryland				Laurel	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Rt #1 Box 412		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Laurel General Hospital					
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH Month Day Year	
Alberta Mae Herberson				June 22 1958	
5 SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
Female	White		Feb. 20, 1910	48	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Home		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Cornelius Martin Frye		Idella Reed		USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address	
No				Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma DUE TO Carcinoma Ovary Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
June 18, 1958				(City or town) (County) (State)	
21. I certify that I attended the deceased from June 18, 1958, to June 22, 1958, that I last saw the deceased alive on June 22, 1958, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE Oscar B. Campbell M.D.		CSD Washington Blvd.			
PRINTED NAME (Type) OSCAR B. CAMPBELL, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
Burial		June 25, 1958		Loy Hill Cemetery Laurel Maryland	
23 FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 26 '58	
H. W. Witham & Sons Laurel Md				24b. REGISTRAR'S SIGNATURE	

VS A15 (4)  
15A (5)  
15A (5)



7199

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Saint Pleasant</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Saint Pleasant</u>			
c. LENGTH OF STAY IN 1b <u>45 years</u>				d. STREET ADDRESS <u>6509 Central Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6509 Central Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LILLIE MAE HERN</u>				4. DATE OF DEATH <u>June 15 1955</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 15 1891</u>	
9. AGE in years (last birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>House Wife</u>		11. BIRTHPLACE (State or foreign country) <u>North DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph W. Lunsell</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Robey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>47-68th Ave</u>			
17. INFORMANT <u>Mrs Margaret McLaughlin</u>				Address <u>47-68th Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO (b) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>May 11, 1955</u> to <u>June 15, 1955</u> , that I last saw the deceased alive on <u>June 14, 1955</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Brainin</u> M.D.				ADDRESS (Street, city or town, state) <u>6124 Central Ave</u>			
PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>				DATE SIGNED <u>6/15/55</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6-17-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Capitol Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Stittland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - DC</u>				ADDRESS _____		24a. REC'D BY REGISTRAR <u>JUN 17 '55</u>	
				24b. REGISTRAR'S SIGNATURE _____			



FOR STATE  
HEALTH DEPT.

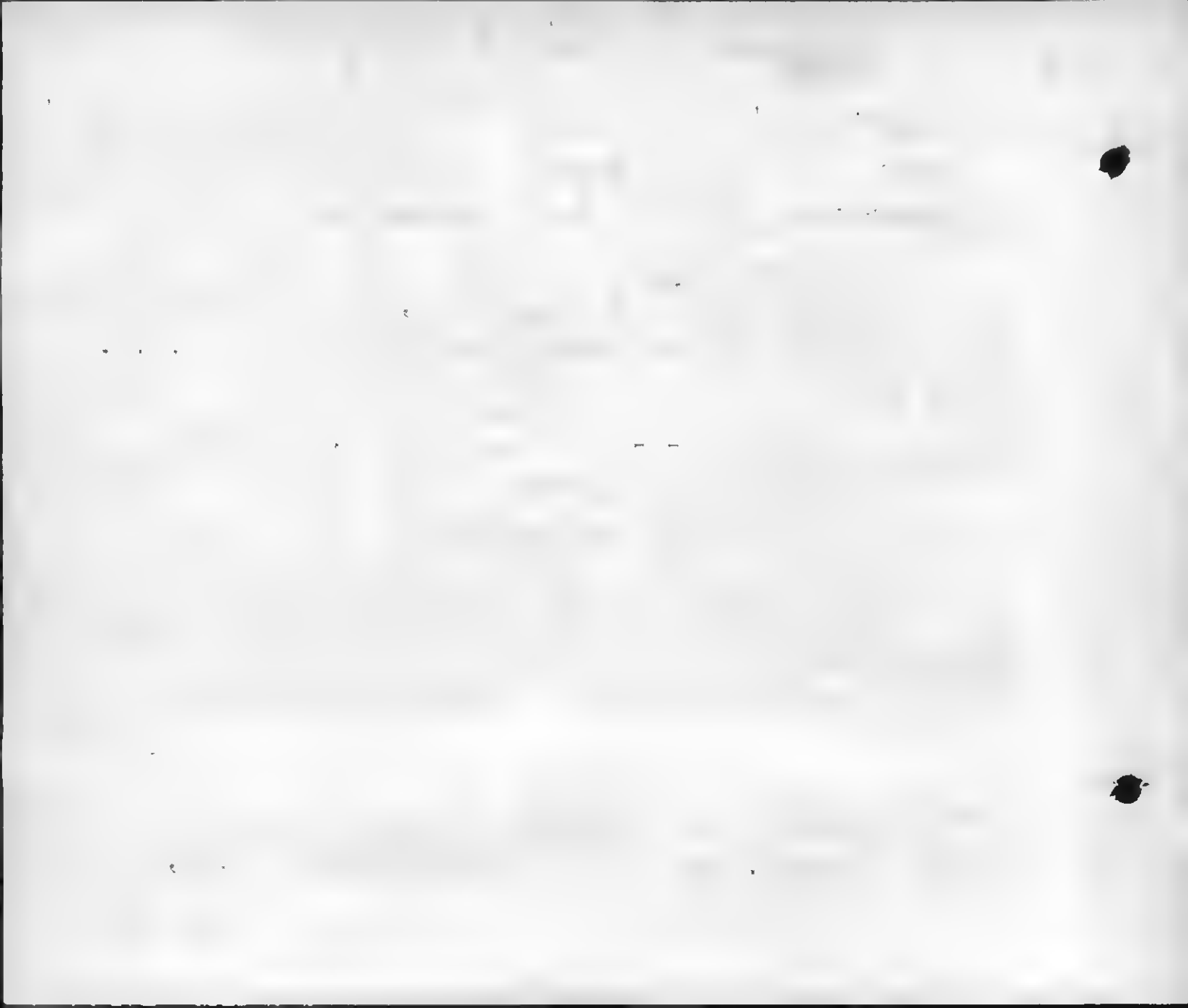
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7200 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07150

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berkshire</b>		c. LENGTH OF STAY IN 1b <b>6 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7410 Nyack Place</b>		d. STREET ADDRESS <b>7410 Nyack Place</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Clayton John Hollen</b>		4. DATE OF DEATH Month Day Year <b>June 4 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 7, 1915</b>
9. AGE (In years last birthday) <b>43</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Vending machines</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Ellis Hollen</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>171-07-5036</b>	
17. INFORMANT <b>Mrs Dorothy Hollen, same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>400.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular renal disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		DATE SIGNED <b>June 5, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-7-1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James T. Ryan, Inc. 317 P. Ave., S. E.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 9 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>W. Reduch</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**7201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07151

**FOR STATE HEALTH DEPT.**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baden</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baden</u>	
c. LENGTH OF STAY IN 1b <u>40 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home Head Road</u>		d. STREET ADDRESS <u>Home Head Road</u>	
3. NAME OF DECEASED (Type or print) <u>William Edgar Hyde</u>		4. DATE OF DEATH <u>June 16 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1888</u>
9. AGE (in years last birthday) <u>69</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. - R</u>	
13. FATHER'S NAME <u>George Hyde</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Cook</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Elizabeth L. Baden</u>	
17. INFORMANT <u>Elizabeth L. Baden</u>		Address <u>Brandywine Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> (b) <u>Shot gun wound of chest</u> (c) <u>1/6X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with shot gun</u>	
20c. TIME OF INJURY Month, Day, Year <u>June 6 1958</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20e. (City or town) <u>Baden</u>		20f. (County) <u>P. G. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/18/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		22d. LOCATION (City, town, or county) <u>Baden, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Upper Marlboro, Md.</u>		24a. REC'D BY REGISTRAR <u>June 20 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Robert</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within 72 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



7144

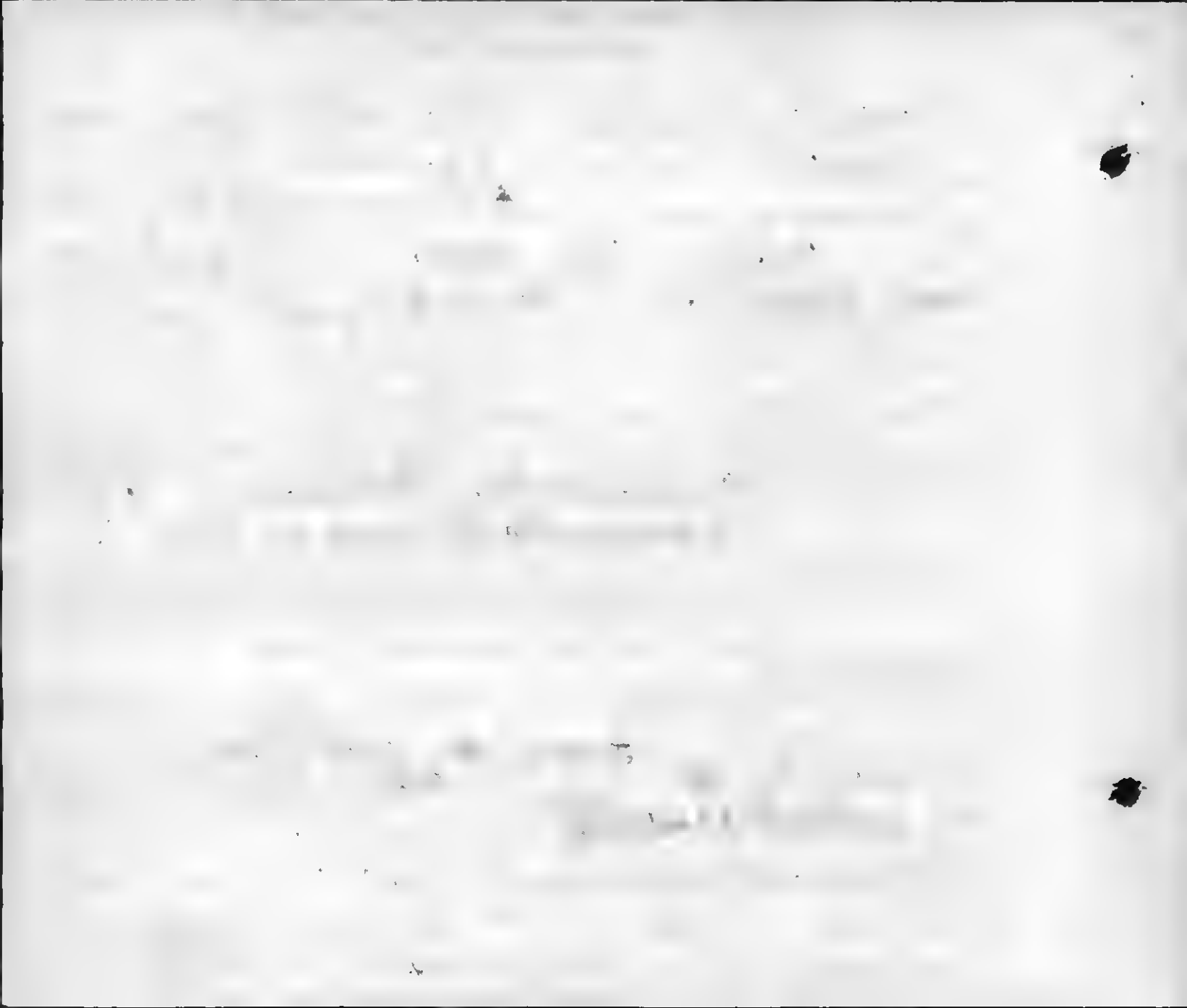
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>PRINCE GEORGE'S</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIVERDALE</b>	c. LENGTH OF STAY IN 1b <b>1-2 weeks</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5301 Greenway Ave.</b>		d. STREET ADDRESS <b>5301 Greenway Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>LEE</b> Last <b>JOHNSON</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>7</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 23, 1878</b>
9. AGE (In years last birthday) <b>79</b> yrs		IF UNDER 1 YEAR: Months <b>7</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Pearson</b>	
14. MOTHER'S MAIDEN NAME <b>Etta Pearson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>	
16. SOCIAL SECURITY NO. <b>Yes</b>		17. INFORMANT <b>John D. Meade</b> Address <b>5301 Greenway Ave. Riverdale, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease ?</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>JUNE 6, 1958</b> , to <b>JUNE 7, 1958</b> , that I last saw the deceased alive on <b>JUNE 7, 1958</b> , and that death occurred at <b>10:45</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5301 ANNAPOLIS RD. BLADENBURGH, MD.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>William D. Ross</b> M.D.			
PHYSICIAN'S NAME (Type) <b>WILLIAM D. ROSSON</b> <b>BLADENBURGH, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-10-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Shutland Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co. Inc. 517-11th St. A. E.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 10 58</b>	24b. REGISTRAR'S SIGNATURE <b>W. W. Chambers</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7145

CERTIFICATE OF DEATH

07154

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>17 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mitchellsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				g. STREET ADDRESS <u>151 Church Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fannie</u> Middle <u>Johnson</u> Last		4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>19 58</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>5 Nov. 1879</u>		9. AGE (In years last birthday) yrs <u>80</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) A <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Clara Brown 151 Church Road, Mitchellville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 157x DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 19</u> , 19 <u>58</u> to <u>June 5</u> , 19 <u>58</u> that I last saw the deceased alive on <u>June 5</u> , 19 <u>58</u> and that death occurred at <u>2:00</u> A. M. from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Norman Corcoran</u> M.D.				ADDRESS (Street, city or town, state) <u>3503 Cherry St. Mt Rainier Md</u> DATE SIGNED <u>6/6/58</u>			
PHYSICIAN'S NAME (Type) <u>Norman Corcoran, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Woodmore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Stewart</u> ADDRESS <u>30 H Street, N.E. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07454

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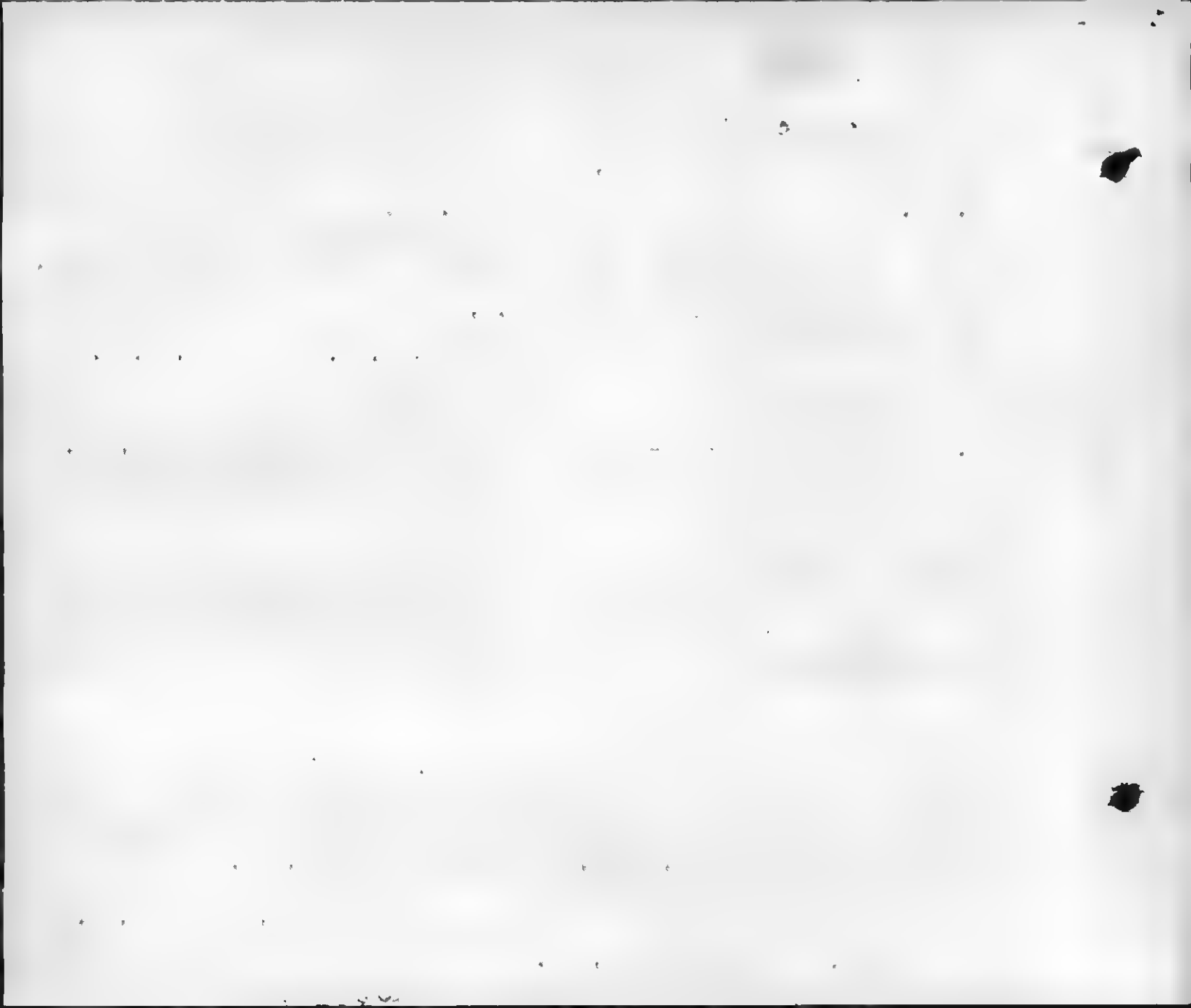
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges!</u> <u>MARYLAND</u>		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges!</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>	
c. LENGTH OF STAY IN 1b <u>13 yrs.</u>		d. STREET ADDRESS <u>Rt. #4.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. #4.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Catherino</u> Middle <u>Pauly</u> Last <u>Kelly</u>		4. DATE OF DEATH Month <u>June</u> Day <u>30</u> , Year <u>1958.</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 8, 1869</u>
9. AGE (In years last birthday) <u>89</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11 BIRTHPLACE (State or foreign country) <u>Albany, N. Y.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Casper Pauly</u>		14. MOTHER'S MAIDEN NAME <u>Mary Mueller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16 SOCIAL SECURITY NO <u>-----</u>	
17 INFORMANT <u>John Lewis Kelly-</u>		Address <u>Upper Marlboro, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Conjunctive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> (c) <u>  </u> DUE TO <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary Anemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 2, 1958</u> to <u>June 30, 1958</u> , that I last saw the deceased alive on <u>June 29, 1958</u> , and that death occurred at <u>8:05 P.</u> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>James R. Sasscer</u> M.D.		ADDRESS (Street, city or town, state) <u>Upper Marlboro, Md.</u>	
PHYSICIAN'S NAME (Type) <u>James G. Sasscer, M. D.</u>		DATE SIGNED <u>7-1-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/4/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Agnes Catholic Cem;</u>		22d. LOCATION (City, town, or county) (State) <u>Albany, N. Y.</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros.</u>		ADDRESS <u>Upper Marlboro, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





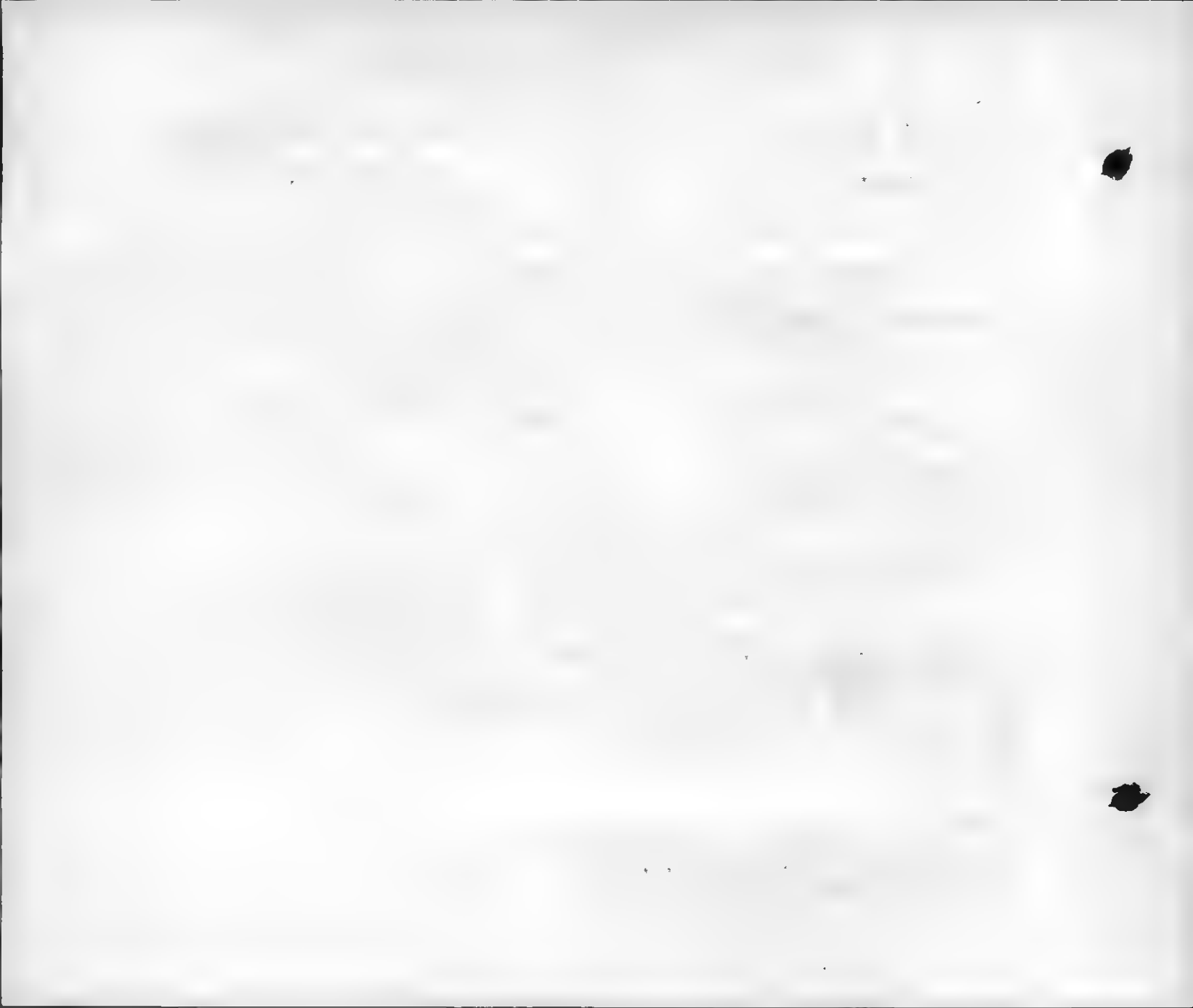
7146

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY <b>Prince George</b> b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md.</b>		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Prince George</b> c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>6200 Pontiac St., Berwyn Heights, Md.</b>	
3 NAME OF DECEASED (Type or print) <b>Sarah</b> First Middle Last <b>Kielsohn</b>		4 DATE OF DEATH Month Day Year <b>June 8, 1958</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>5/8/90</b>
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		9b KIND OF BUSINESS OR INDUSTRY <b>RUSSIA</b>	
10a CITIZEN OF WHAT COUNTRY? <b>USA</b>		11 BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	
12 FATHER'S NAME <b>JOSEPH FINE</b>		13 MOTHER'S MAIDEN NAME <b>RACHEL BERGER</b>	
14 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		15 SOCIAL SECURITY NO. <b>183-42-ARCADIA AVE</b>	
16 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> DUE TO <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>10-12 years</b> DUE TO (c) <b>Gastric Hemorrhage</b>		17 INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
18 PARTIAL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>100.0</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May - 5, 1957</b> to <b>6/8, 1958</b> , that I last saw the deceased alive on <b>6-7, 1958</b> , and that death occurred at <b>9:25 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>6-8-58</b> DATE SIGNED <b>6-8-58</b>			
ACTUAL SIGNATURE <b>William M. Eisner M.D.</b>			
PHYSICIAN'S NAME (Type) <b>William M. Eisner M.D.</b>			
22a BURIAL, CREMATION, REMOVAL (Specify)	22b DATE THEREOF <b>6-10-58</b>	22c NAME OF CEMETERY OR CREMATORY <b>UNITED HEBREW CEM.</b>	22d LOCATION (City, town, or county) (State) <b>STATEN ISLAND NY</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Langansky &amp; Son</b>		24a REC'D BY REGISTRAR <b>JUN 10 '58</b>	24b REGISTRAR'S SIGNATURE <b>W. Eisner</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7147 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07156

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> c. LENGTH OF STAY IN 1b _____		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> d. STREET ADDRESS <u>6303-Inwood Street</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Margaret Dick King</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>June 4-1958</u> Month Day Year	
<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>1-8-75</u> <b>9. AGE</b> (In years last birthday) <u>83</u> yrs. <b>10. IF UNDER 1 YEAR</b> Months _____ Days _____ <b>11. IF UNDER 24 HRS.</b> Hours _____ Min _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (State or foreign country) <u>New York</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>William W. Stoddard</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (If yes, give war and dates of service) _____		<b>14. MOTHER'S MAIDEN NAME</b> <u>Phoebe Anna Dick</u> <b>16. SOCIAL SECURITY NO.</b> _____ <b>17. INFORMANT</b> <u>Octavia Rouzeau; same address.</u> Address _____	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>442X</u> DUE TO (b) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) _____	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour _____ a. m. _____ p. m. _____ 19____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____	
<b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>John J. Maloney</u> <b>EXAMINER'S NAME (Type)</b> <u>JOHN T. MALONEY M.D.</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <u>6-4-58</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Transportation</u> <b>22b. DATE THEREOF</b> <u>6/5/58</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Flushing</u> <b>22d. LOCATION</b> (City, town, or county) <u>New York</u> (State) _____	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>L. Gasch's Sons</u> <b>ADDRESS</b> <u>Hyattsville Maryland.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>JUN 6 '58</u> <b>24b. REGISTRAR'S SIGNATURE</b> _____	



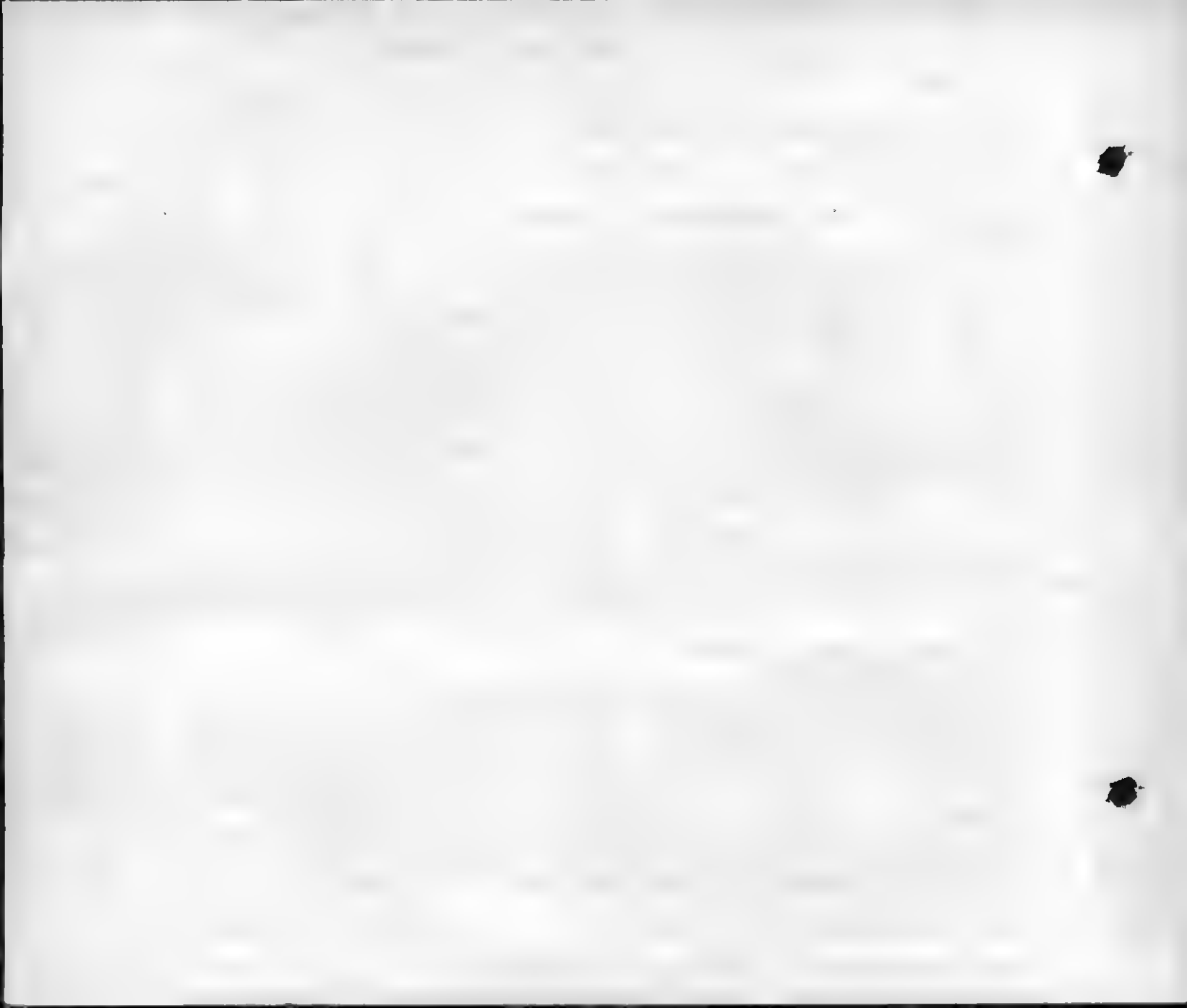
07157

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>P.G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>16613 24th Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6613 24th Ave. (Daughter's home)</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rose Marie Khoppman</u>		4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 23-1878</u>
9. AGE in years (last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pittsburgh Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Neal</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT (Name and address) <u>Mr. Hennings 6613 24th Ave Hyattsville</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro-vascular Accident</u> DUE TO <u>Gen. Arteriosclerotic Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c) <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary Anemia &amp; Senility</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. p. <u>19</u> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 31, 1958</u> to <u>June 6, 1958</u> , that I last saw the deceased alive on <u>June 5, 1958</u> , and that death occurred at <u>3:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. X. Courtney</u>		DATE SIGNED <u>June 6/58</u>	
PHYSICIAN'S NAME (Type) <u>J. X. Courtney M.D.</u>		ADDRESS (Street, city or town, state) <u>5601-40th St West Hyattsville</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-9-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>Pittsburgh Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tom Lee &amp; Sons</u>		ADDRESS <u>Washington DC</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 9 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. ...</u>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7148

## CERTIFICATE OF DEATH

Reg. Dist. No. 07158

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>6 Hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Knically</b>				4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-16-58</b>	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>Robert Knically Unknown</b>			
14. MOTHER'S MAIDEN NAME <b>Frances Knically</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO				17. INFORMANT <b>mother - as above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 16, 1958</b> , to <b>June 16, 1958</b> , that I last saw the deceased alive on <b>June 16, 1958</b> , and that death occurred at <b>10:00PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John W. Perkins</b>				ADDRESS (Street, city or town, state) <b>5301 Hamlet St, Hyattsville, Md</b>			
PHYSICIAN'S NAME (Type) <b>John W. Perkins</b>				DATE SIGNED <b>6/12/58</b>			
22a. BURIAL, CREMATION, OR OTHER DISPOSITION <b>Funeral Home</b>		22b. DATE THEREOF <b>June 23/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hosp., Cheverly, Maryland</b>		22d. LOCATION (City, town or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn</b>				ADDRESS <b>Cheverly, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 24 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. To be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 7203 CERTIFICATE OF DEATH

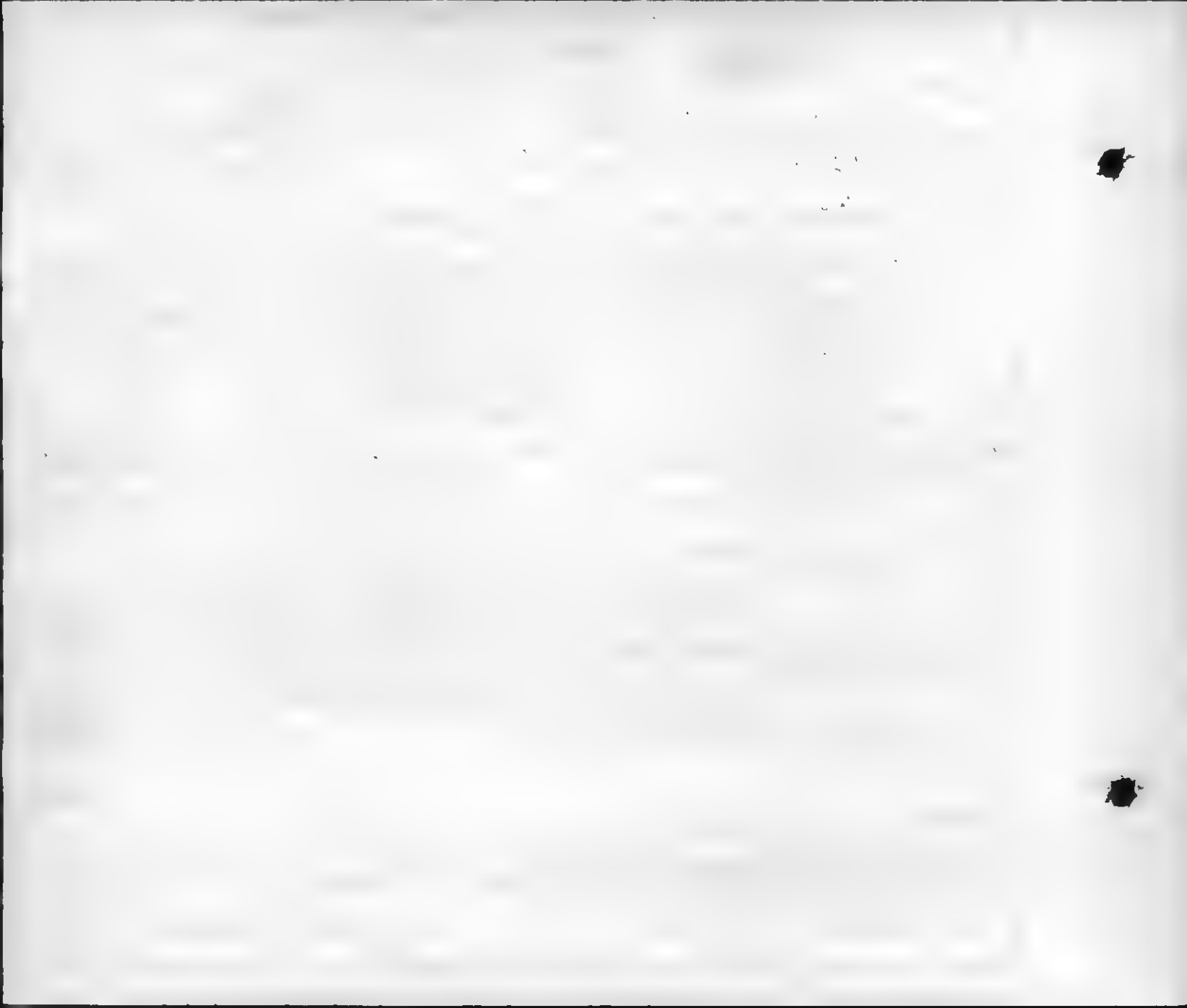
Reg. Dist. No.

07159

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland md. Washington 23 DC</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4815 Suitland Rd</u>				d. STREET ADDRESS <u>4815 Suitland Rd SE</u>			
3. NAME OF DECEASED (Type or print) <u>George Wesley Lawrence</u>				4. DATE OF DEATH <u>June 23 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>US White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7 1900</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Lawrence</u>				14. MOTHER'S MAIDEN NAME <u>Sara Francis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>22611571</u>		17. INFORMANT <u>Wife</u> Address <u>4815 Suitland Rd SE Washington 23 DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombotic hemorrhage</u> <u>3.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Car accident of Motor vehicle</u> DUE TO (c) <u>2nd instance</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Natural Causes</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 23</u> , 1958, to <u>June 23</u> , 1958, that I last saw the deceased alive on <u>June 23</u> , 1958, and that death occurred at <u>5:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul C. LaNails</u> M.D.				DATE SIGNED <u>June 25 1958</u>			
PHYSICIAN'S NAME (Type) <u>PAUL C. LA NAILS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-26-58</u>		<u>Cedar Hill</u>		<u>Suitland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u> ADDRESS <u>1661 Good Hope Rd SE Wash. DC</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				<u>June 25 1958</u>		<u>Alberson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



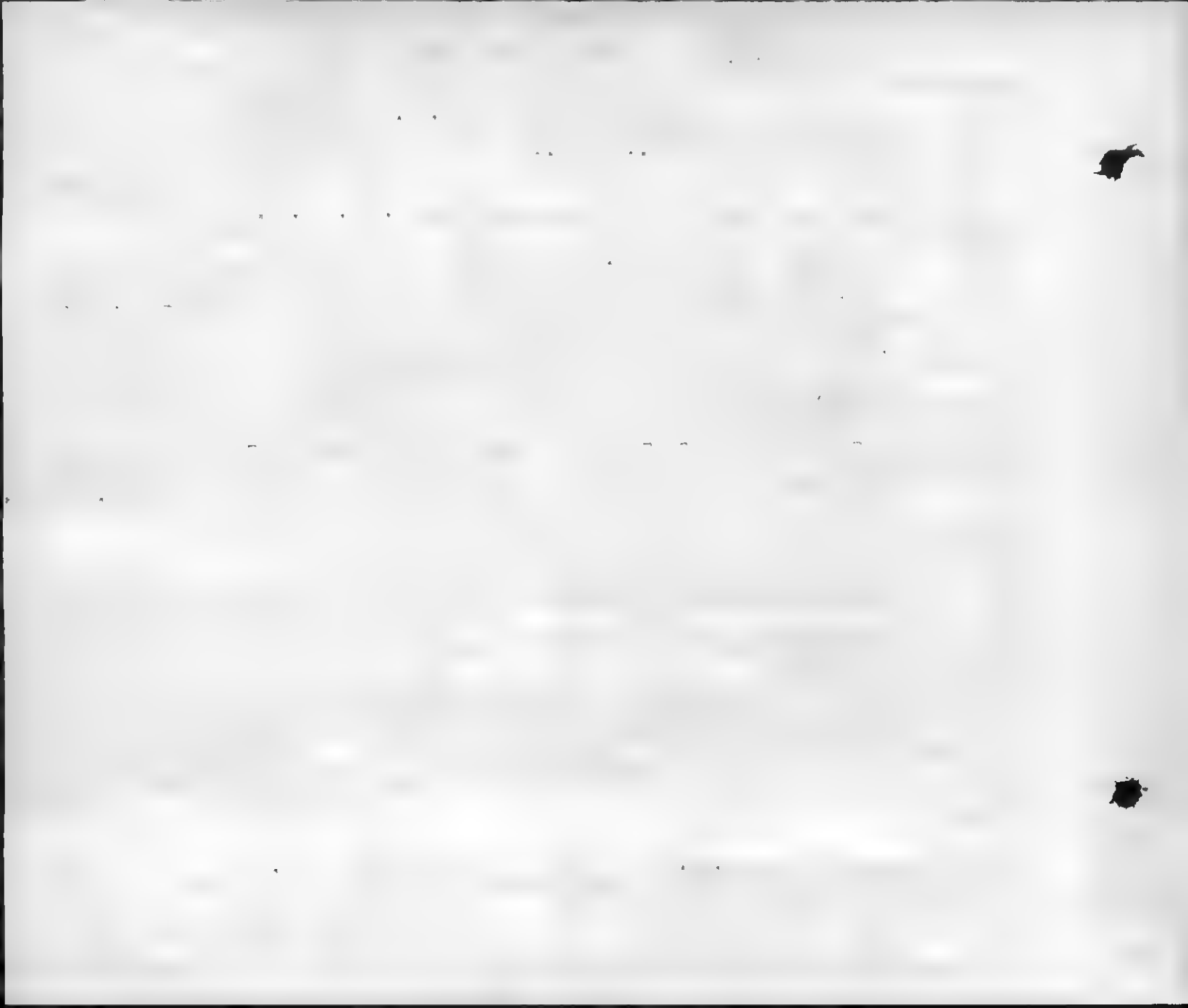
7204

CERTIFICATE OF DEATH

Reg. Dist. No.

07160

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 1 yr. 8 mos. & 30 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 920 E. St., N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lewis Moulton Lawrence			4. DATE OF DEATH Month Day Year 6 11 19 58				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/13/1896		9. AGE (In years last birthday) 61 yrs	IF UNDER 1 YEAR Months Days Hours Min. — — — —	IF UNDER 24 HRS. — — — —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail clerk		10b. KIND OF BUSINESS OR INDUSTRY Advertising Distribution of Washington		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Lawrence				14. MOTHER'S MAIDEN NAME Minnie Moulton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes —		16. SOCIAL SECURITY NO. 267-01-4761		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emphysema and cor pulmonale							INTERVAL BETWEEN ONSET AND DEATH 8 yrs., & 1 mo.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/12, 1956, to 6/11, 1958, that I last saw the deceased alive on 6/11, 1958, and that death occurred at 5:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Glenn Dale Hospital 6/11/58 ACTUAL SIGNATURE Moe Weiss M.D. PHYSICIAN'S NAME (Type) Moe Weiss, M. D. Glenn Dale, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/13/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Frost Moyer Va.	
23. FUNERAL DIRECTOR'S SIGNATURE H. H. Chamber Co.				ADDRESS 1400 Chapin St. N.W.		24a. REC'D BY REGISTRAR DATE JUN 17 1958	
				24b. REGISTRAR'S SIGNATURE R. H. ...			



7205

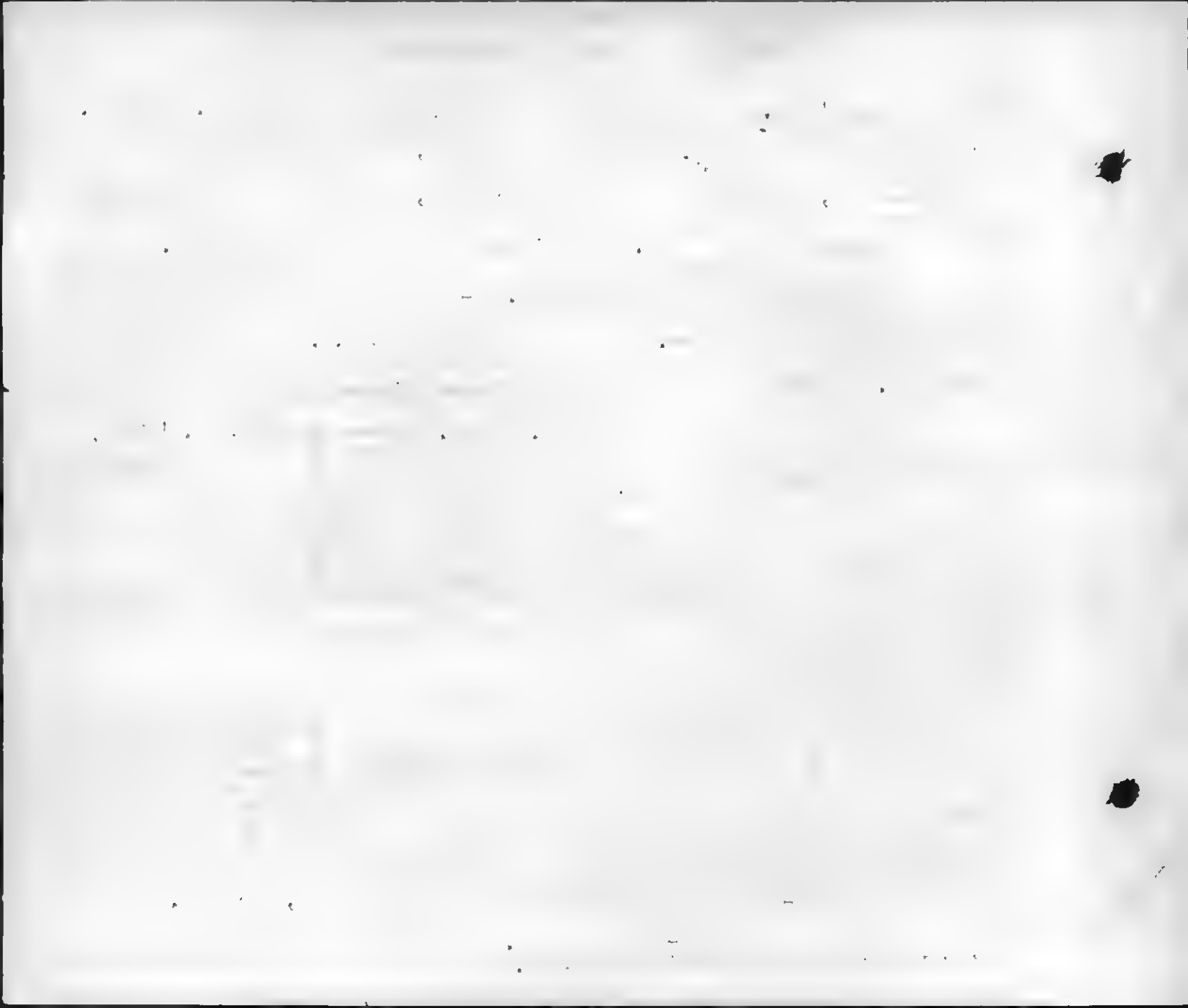
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's Co.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Accokeek</b>		c. LENGTH OF STAY IN 1b <b>8 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Accokeek, Maryland</b>		d. STREET ADDRESS <b>Accokeek, Maryland</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FRIEDRICH</b> Middle <b>G.</b> Last <b>LINDNER</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>4th.</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 12- 1902</b>
9. AGE (In years last birthday) yrs. <b>56</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own.</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Johann M. Lindner</b>		14. MOTHER'S MAIDEN NAME <b>Rosina Lindner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Emma R. Lindner Accokeek, Md. (Wife)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>410X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Rheumatic Heart Disease</b> DUE TO (c) <b>Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Controlled Hypertension</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1955</b> to <b>June 3, 1958</b> that I last saw the deceased alive on <b>June 3, 1958</b> , and that death occurred at <b>5 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>J. H. Yorkhoff</b> M.D. <b>3127 Nichols Ave SE</b>			
PHYSICIAN'S NAME (Type) <b>J. H. Yorkhoff M.D.</b> <b>Washington, D.C.</b>			
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 6-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sommers Brothers</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 5 '58</b>	
ADDRESS <b>1661- Good Hope Rd. SE</b> <b>Washington 20, D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the Registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



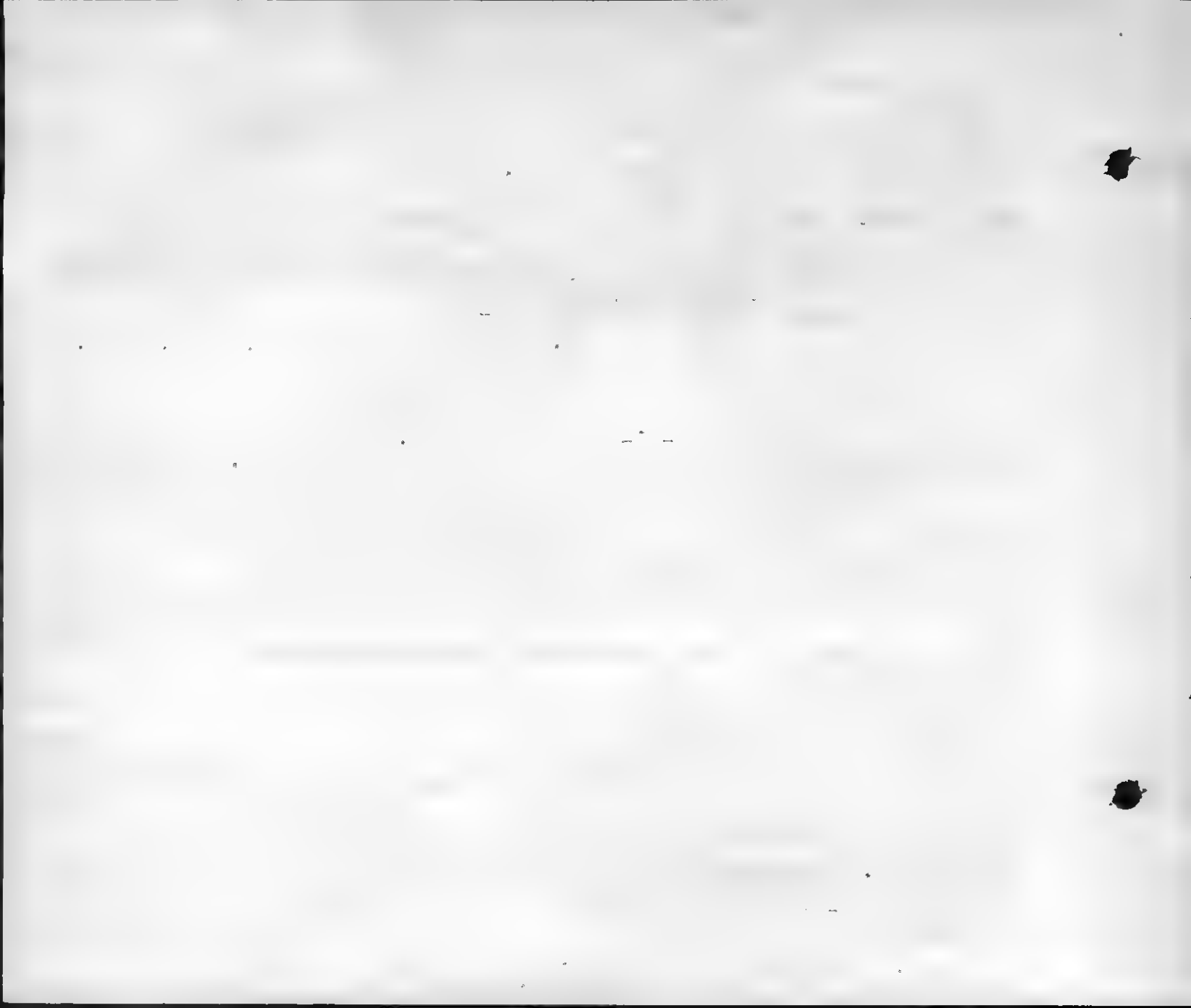
7149

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 Day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>W. Hyattsville 15</b>	
f. STREET ADDRESS <b>2605 Lackawanna St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Edward</b> Last <b>Lintelman</b>		4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED	8. DATE OF BIRTH <b>9-2-98</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Western Elec.</b>	
11. BIRTHPLACE (State or foreign country) <b>Wilkinsburg Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Edward Lintelman</b>		14. MOTHER'S MAIDEN NAME <b>Anna Niemeyer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>169-01-5635</b>	
17. INFORMANT <b>Richard B. Stewart</b>		Address <b>2605 Lackawanna St W. Hyattsville Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Peritonitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Perf. Anterior gastric ulcer</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6-1</b> , 19 <b>58</b> , to <b>6-2</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6-2</b> , 19 <b>58</b> , and that death occurred at <b>12:25 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Hyattsville Md</b> DATE SIGNED <b>6-2-58</b>			
ACTUAL SIGNATURE <b>Dr. Aaron Deitz</b>		M. D. <b>Hyattsville Md</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Aaron Deitz</b>			
22a. BURIAL, CREMATION, or other disposal of body <b>Removed</b>	22b. DATE THEREOF <b>6-2-'58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Unknown</b>	22d. LOCATION (City, town, or county) (State) <b>Pittsburgh Penna</b>
23. REGISTRAR'S SIGNATURE <b>W. W. Chambers Co</b>		24a. REC'D BY REGISTRAR <b>JUN 4 '58</b>	
ADDRESS <b>5801 Cleve. Ave. Riverdale Md.</b>		24b. REGISTRAR'S SIGNATURE <b>W. W. Chambers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE  
HEALTH DEPT.

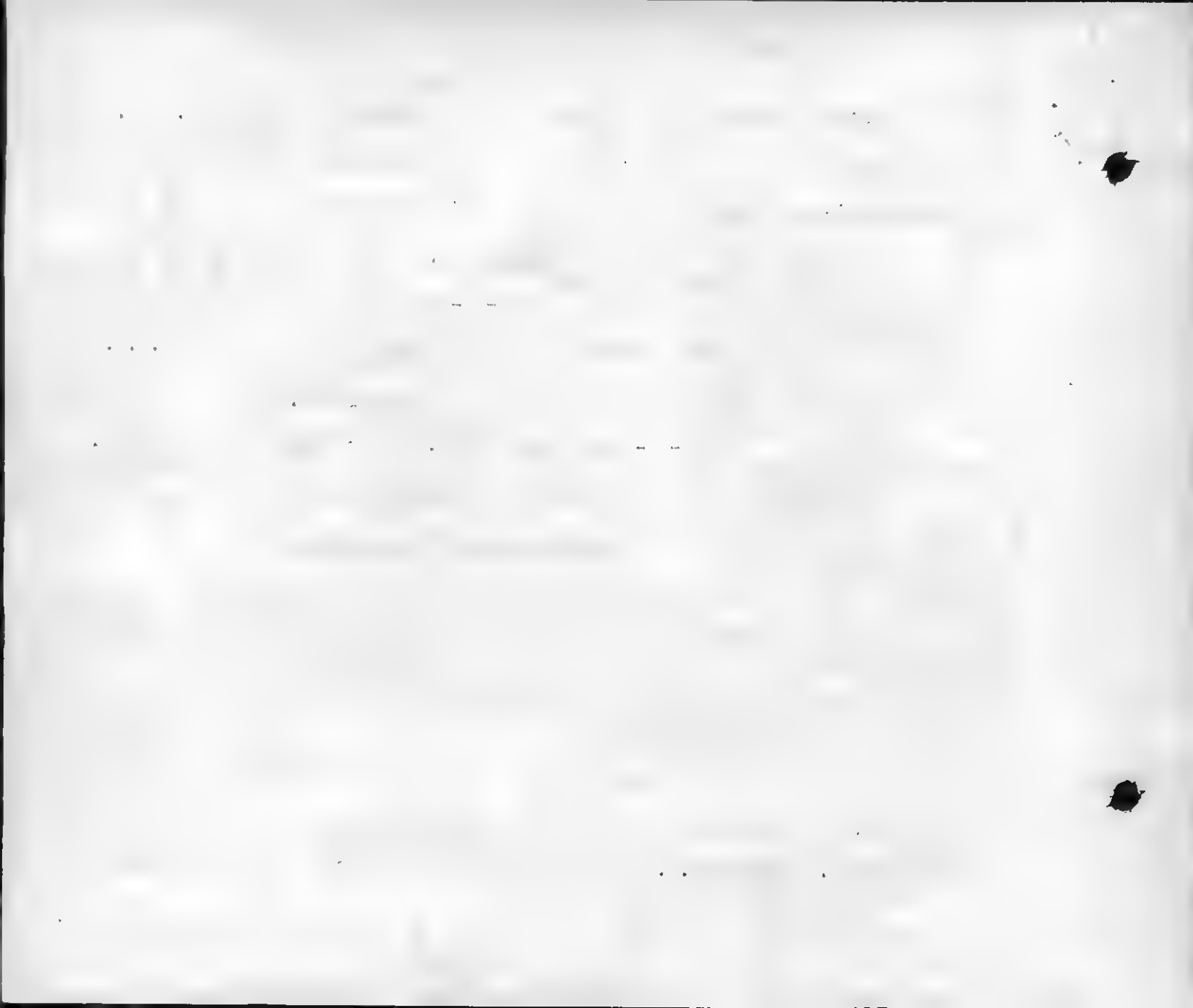
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07163

7150

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>1 year</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b>	
3. NAME OF DECEASED (Type or print) <b>John Joseph Luby, Jr.</b>		4. DATE OF DEATH <b>June 11 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-11-21</b>
9. AGE (In years last birthday) <b>36</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Broker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Joseph Luby</b>		14. MOTHER'S MAIDEN NAME <b>Margaret E. Neal</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>577-24-8816</b>	
17. INFORMANT <b>Margaret E. Robert;</b>		Address <b>same address as # 2.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b>			
DUE TO (b) <b>Cardiovascular renal disease</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchial asthma</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>June 11, 1958</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 14, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Washington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Pr. Geo. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Maloney</b>		24a. REC'D BY REGISTRAR <b>June 13 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>John T. Maloney</b>			



7120

## CERTIFICATE OF DEATH

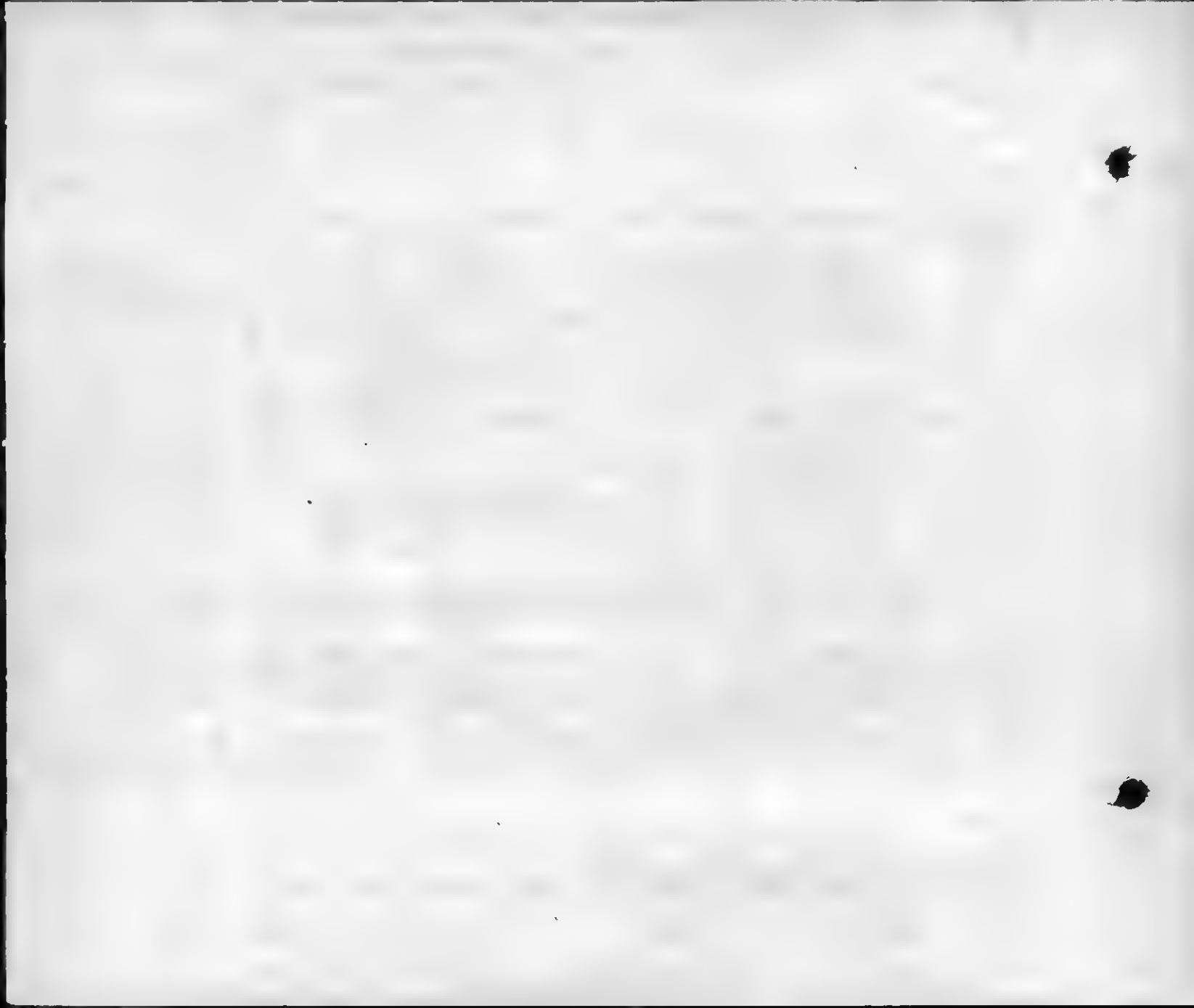
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>B. Leo</u> MARYLAND		2. USUAL RESIDENCE Where deceased lived If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Residence</u>		d. STREET ADDRESS <u>6107 Eastern Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH NELSON LUCAS</u>		4. DATE OF DEATH Month Day Year <u>June 19, 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-11-09</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George N. Lucas</u>		14. MOTHER'S MAIDEN NAME <u>Mary V. Babec.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Mary V. Lucas - mother</u>	
17. INFORMANT <u>Mary V. Lucas - mother</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. <u>Recurrent coronary insufficiency</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr 40 min</u> <u>1 month</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 18, 1958</u> to <u>June 19, 1958</u> that I last saw the deceased alive on <u>June 19, 1958</u> , and that death occurred at <u>12:10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sydney Leventhal</u> M.D.		ADDRESS (Street, city or town, state) <u>9210 Oakville Rd., Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Sydney Leventhal, M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>6-21-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	22d. LOCATION (City, town or county) (State) <u>Wash. D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - D.C.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>JUN 20 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. A. Church</u>	

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

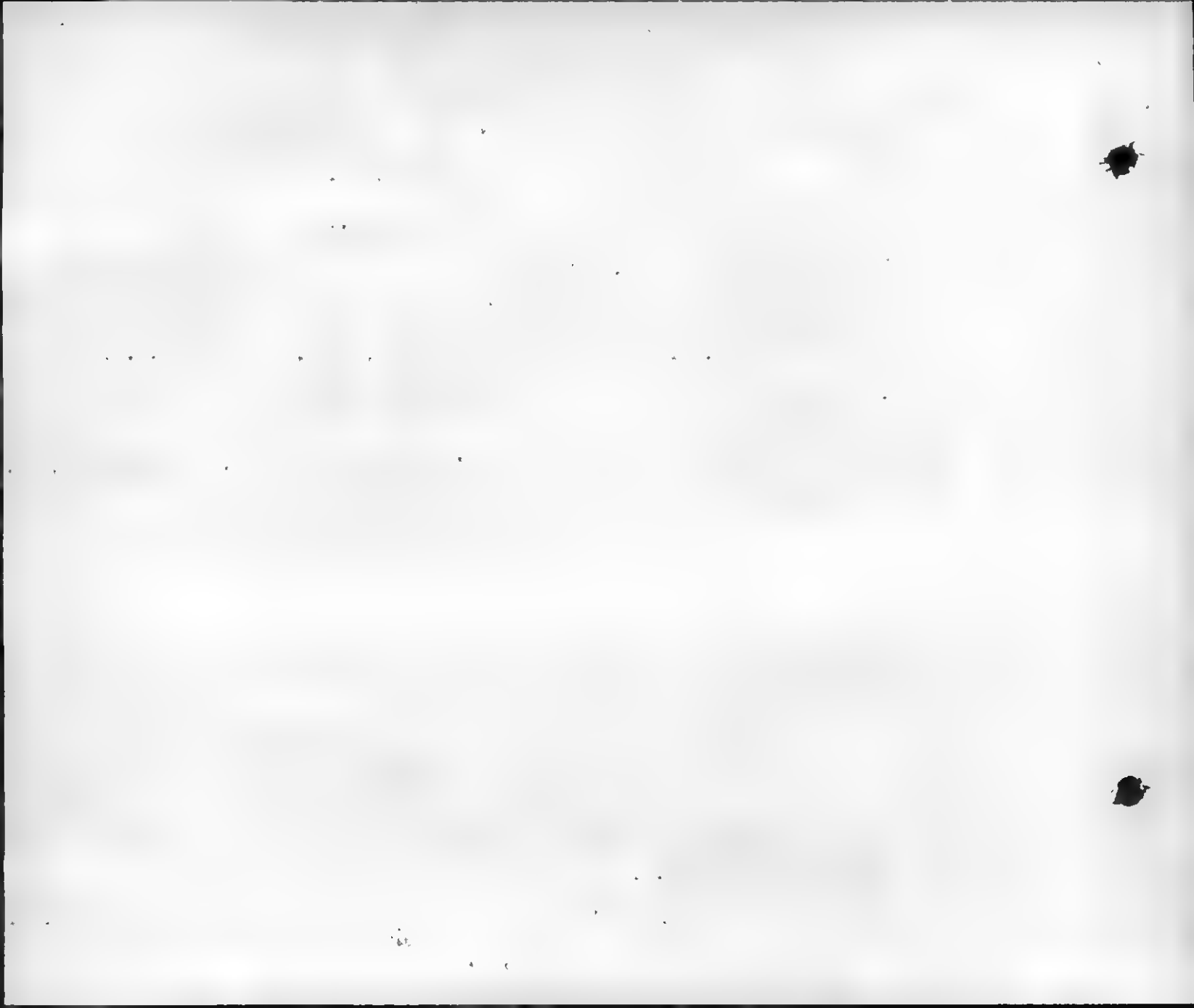
Reg. Dist. No.

07165

7151

1 PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly Md</b> c. LENGTH OF STAY IN 1b <b>1 Month</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's Gen Hospital</b>		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Md.</b> d. STREET ADDRESS <b>5405 37th Ave.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Cornelia MARY XXX Luby</b>		4. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/16/08</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerical</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Government</b>	11. BIRTHPLACE (State or foreign country) <b>Worcester, Mass.</b>
13. FATHER'S NAME <b>Arthur A. Girouard</b>		14. MOTHER'S MAIDEN NAME <b>Cornelia Amelotte</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>William C. Luby 5405 37 Ave., Hyattsville Md.</b>	
17. INFORMANT <b>William C. Luby 5405 37 Ave., Hyattsville Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> DUE TO <b>Parasomnia of the uterus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>+ 11X</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>2-1</b> 19 <b>58</b> to <b>June 12</b> 19 <b>58</b> that I last saw the deceased alive on <b>6-11</b> 19 <b>58</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Hyattsville, Md.</b> DATE SIGNED <b>6-12-58</b>			
ACTUAL SIGNATURE <b>Aaron Dietz M.D.</b>		M.D. <b>Hyattsville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Aaron Dietz M.D.</b>			
22a. BURIAL CREMATION OR REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6/14/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Silver Spring, Montgomery Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b>		ADDRESS <b>Silver Spring, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>JUN 16 58</b>
		24b. REGISTRAR'S SIGNATURE <b>W. E. Humphrey</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

07166

Reg. Dist. No.

7152

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesley</b> c. LENGTH OF STAY IN 1b <b>1 Day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georg's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b> d. STREET ADDRESS <b>IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	
3. NAME OF DECEASED (Type or print) <b>Carrie</b> First Middle Last <b>Mackall</b>		4. DATE OF DEATH <b>June 27</b> Month Day Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-7-87</b>
9. AGE (In years last birthday) <b>70</b>		IF UNDER 1 YEAR Months Days Hours Min <b>19 58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>217300816</b>		17. INFORMANT <b>Horace Owen, Upper Marlboro, Md.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Surgical Shock</b> <b>570.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Mesenteric Thrombosis</b> DUE TO (c) <b>Embolization from Aneurysm of Thoracic Aorta</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours.</b> <b>24 hours.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 26</b> , 19 <b>58</b> , to <b>June 27</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 26</b> , 19 <b>58</b> , and that death occurred at <b>5 A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>5304 Ann... Rd. Cr 27-58</b> <b>Boyleburg Md</b>			
ACTUAL SIGNATURE <b>David Watkins, Md.</b>		PHYSICIAN'S NAME (Type) <b>David Watkins, Md.</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>6-30-58</b>		22b. DATE THEREOF <b>6-30-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Union Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Upper Marlboro, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Myrtle R. Rollins</b>		24a. REC'D BY REGISTRAR <b>JUL 1 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Rollins</b>		24c. REGISTRAR'S SIGNATURE <b>Rollins</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7116 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07167

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. LENGTH OF STAY IN 1b <b>1 1/2 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1300 Nicholson Street Block</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
3. NAME OF DECEASED (Type or print) <b>George Peter Mantzouris</b>		4. DATE OF DEATH <b>June 27, 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1954</b>
9. AGE (in years last birthday) <b>4 yrs</b>		10. IF UNDER 1 YEAR: Months <b>4</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>*****</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Peter George Mantzouris</b>		14. MOTHER'S MAIDEN NAME <b>Carolyn Castle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>*****</b>	
17. INFORMANT <b>Arlington, Va. Thomas Castle; 1605 s. 28th St.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b) <b>Trauma, multiple and severe</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>*****</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Body run over by automobile truck.</b>	
20c. TIME OF INJURY Month, Day, Year <b>9.25 a.m. 6-27-58</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Vacant lot</b>	20f. (City or town) (County) (State) <b>Hyattsville, Pr. Geo. Md.</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>June 27, 1958</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/27/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Wash D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.F. Huntman + Son Inc</b>		24a. REC'D BY REGISTRAR <b>JUL 1 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Rebecca</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 11. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



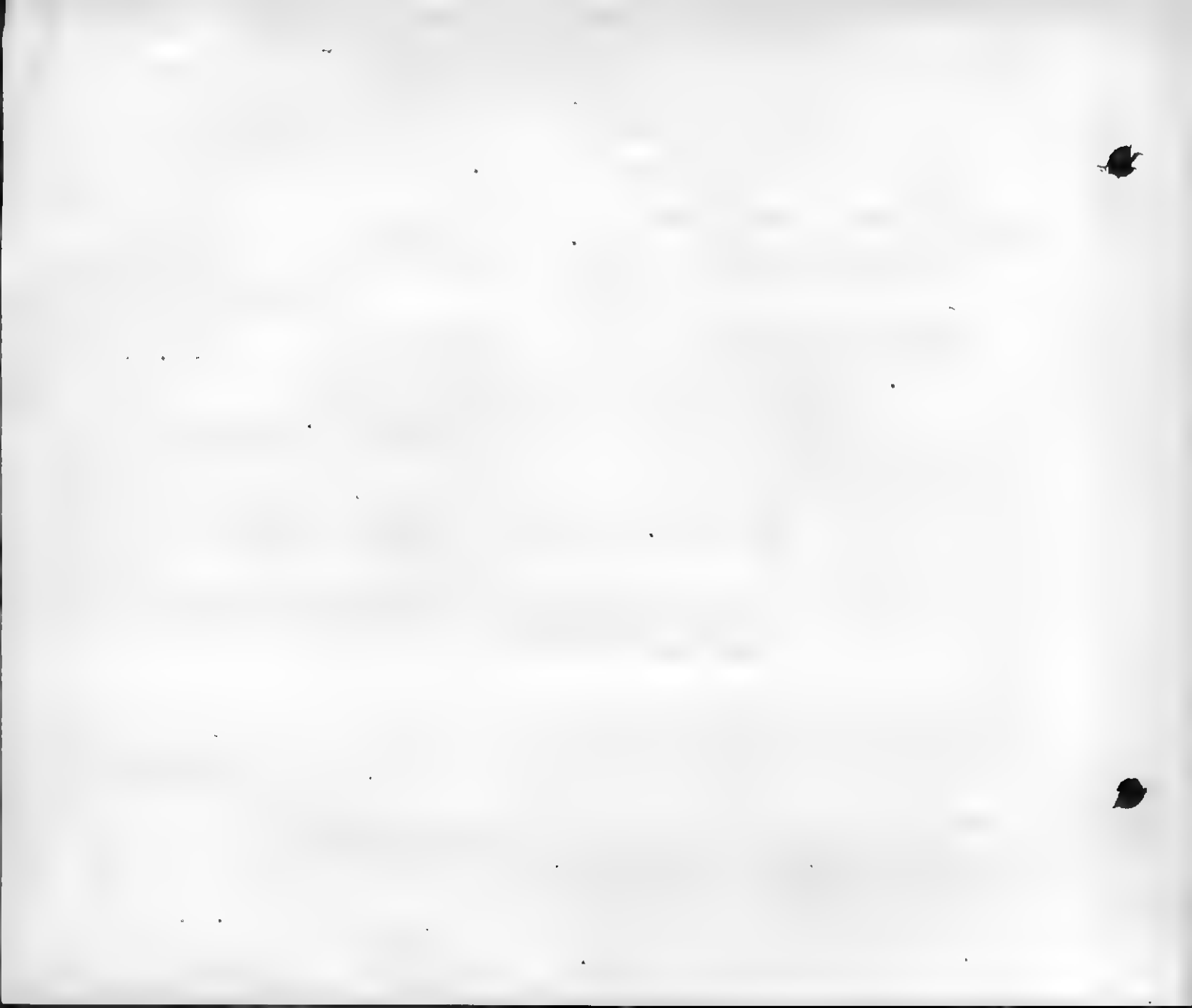
7153

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>26 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. STREET ADDRESS <b>1903 Oliver Street</b>			
3. NAME OF DECEASED (Type or print) <b>(Pete) Pietro</b> First Middle Last				4. DATE OF DEATH <b>June 10 1958</b> Month Day Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-9-76</b> 9. AGE (In years last birthday) <b>82</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Shoemaker</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>	
13. FATHER'S NAME <b>Anten Antoneo Marinari</b>				14. MOTHER'S MAIDEN NAME <b>Maria Sardini</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>?</b>		17. INFORMANT <b>Margaret A Bartley</b> Address <b>Hyattsville Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>1. Broncho pneumonia</b> <b>471X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>2. Mesenteric Thrombosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b> <b>2 weeks</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/16</b> , 19 <b>58</b> to <b>6/10</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6/10</b> , 19 <b>58</b> , and that death occurred at <b>6:30 P.M.</b> , from the causes and on the date stated above							
ACTUAL SIGNATURE <b>Norman Donat Bmeak</b> MD		ADDRESS (Street, city or town, state) <b>3503 Perry St.</b>				DATE SIGNED <b>6/10/58</b>	
PHYSICIAN'S NAME (Type) <b>NORMAN DONAT BMEAK</b>		<b>MT Rainer Md</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/14/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olive Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville Md.</b>				24a. REC'D BY REGISTRAR <b>JUN 16 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Ad. L...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7154 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

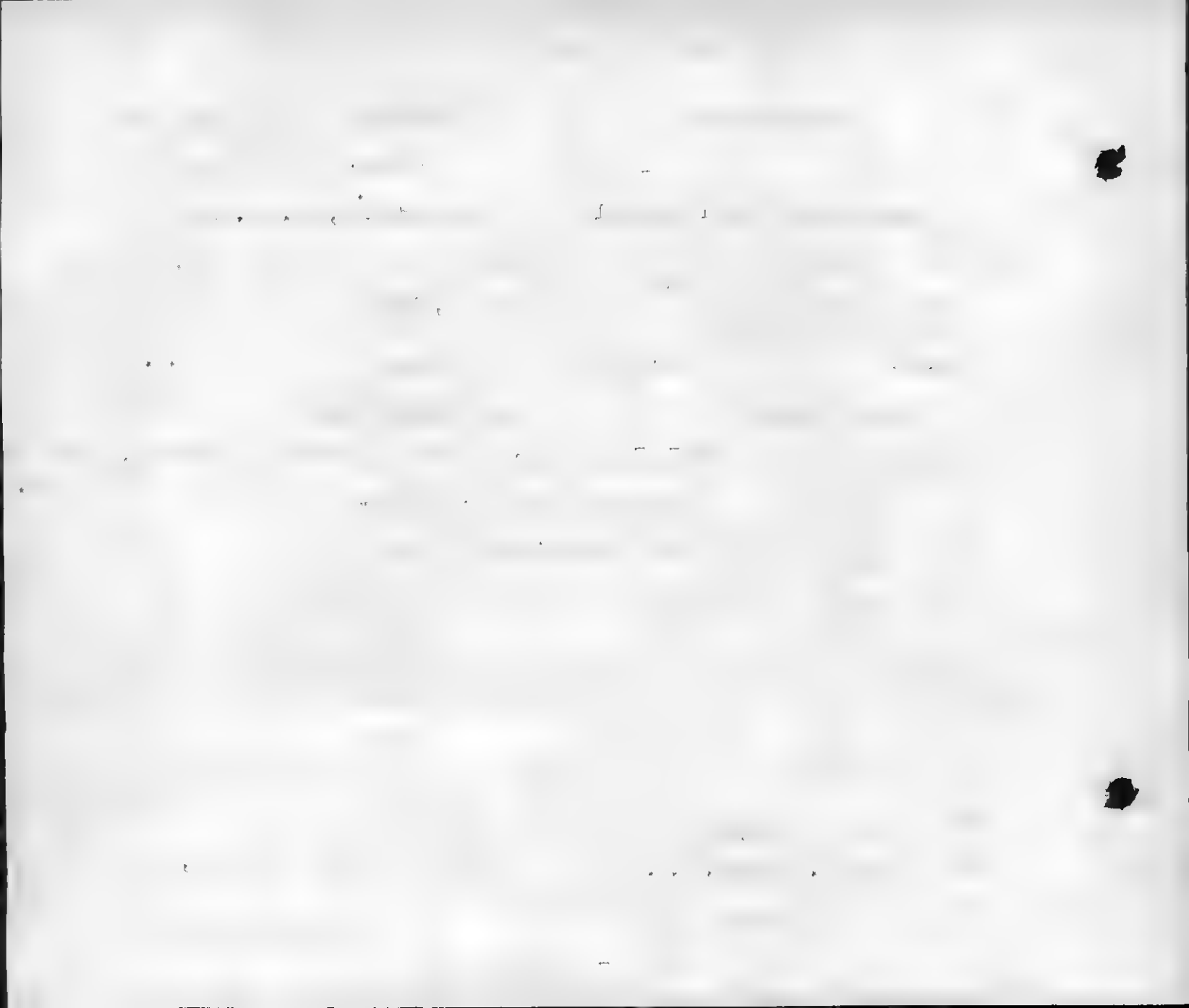
07169

FOR STATE  
HEALTH DEPT.

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Kentucky</u> <u>Maryland</u> b. COUNTY <u>Owsley</u> <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>10 hours</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		e. STREET ADDRESS <u>Rt. 2</u> <u>Wallerstown, Md. Rt. 1</u>	
3. NAME OF DECEASED (Type or print) <u>Irvine</u>		4. DATE OF DEATH <u>June 17, 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1905</u>
9. AGE (In years last birthday) <u>53</u> yrs		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George Marshall</u>		14. MOTHER'S MAIDEN NAME <u>Martha Stone</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>402-01-9522</u>	
17. INFORMANT <u>Harry Simms</u>		Address <u>11908 Colesville Road, Beltsville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (a), stating the underlying cause lost (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John T. Maloney</u>		DATE SIGNED <u>June 18, 1958</u>	
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 21-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Shepherd Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Booneville, Kentucky</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. E. ...</u>		24. REC'D BY REGISTRAR <u>...</u> JUN 20 1958	
ADDRESS <u>Frederick-Maryland</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

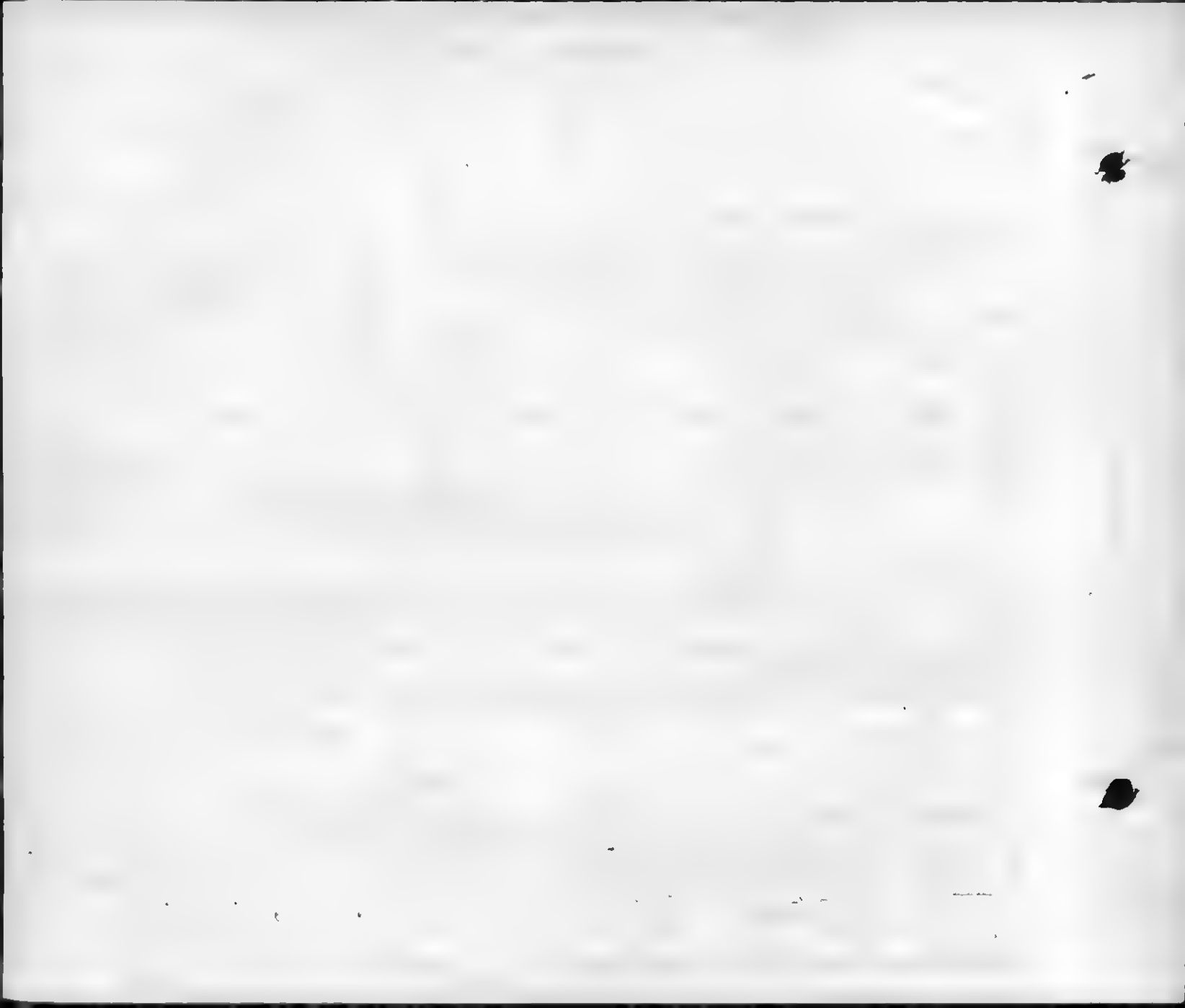
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7117

## CERTIFICATE OF DEATH

Reg. Dist. No. 07170

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47x			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR</u>				d. STREET ADDRESS <u>2115 F St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>A Gnes T. MARTIN</u> First Middle Last				4. DATE OF DEATH <u>June 7 1958</u> Month Day Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 28, 1900</u>		9. AGE (In years last birthday) <u>57</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>		11. BIRTHPLACE (State or foreign country) <u>Tiffin, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Steinmetz</u>				14. MOTHER'S MAIDEN NAME <u>Lena Seifert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Sister M. Jan Thurm</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma to abdomen</u> DUE TO <u>Carcinoma of Sigmoid Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs.</u> <u>4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>April 12, 1958</u> , to <u>June 7, 1958</u> , that I last saw the deceased alive on <u>30 May 1958</u> , and that death occurred at <u>7:40 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1150 Conn. Ave. WASH. D.C.</u> DATE SIGNED <u>June 7, 1958</u>							
ACTUAL SIGNATURE <u>John J. Hughes</u> M.D.				DATE SIGNED <u>June 7, 1958</u>			
PHYSICIAN'S NAME (Type) <u>JOHN J. HUGHES</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/11/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Ft. Myer, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawler's Sons</u> ADDRESS <u>1786 Pa. Ave. N.W. Wash. D.C.</u>				24a. REC'D BY REGISTRAR <u>DATE JUN 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07171

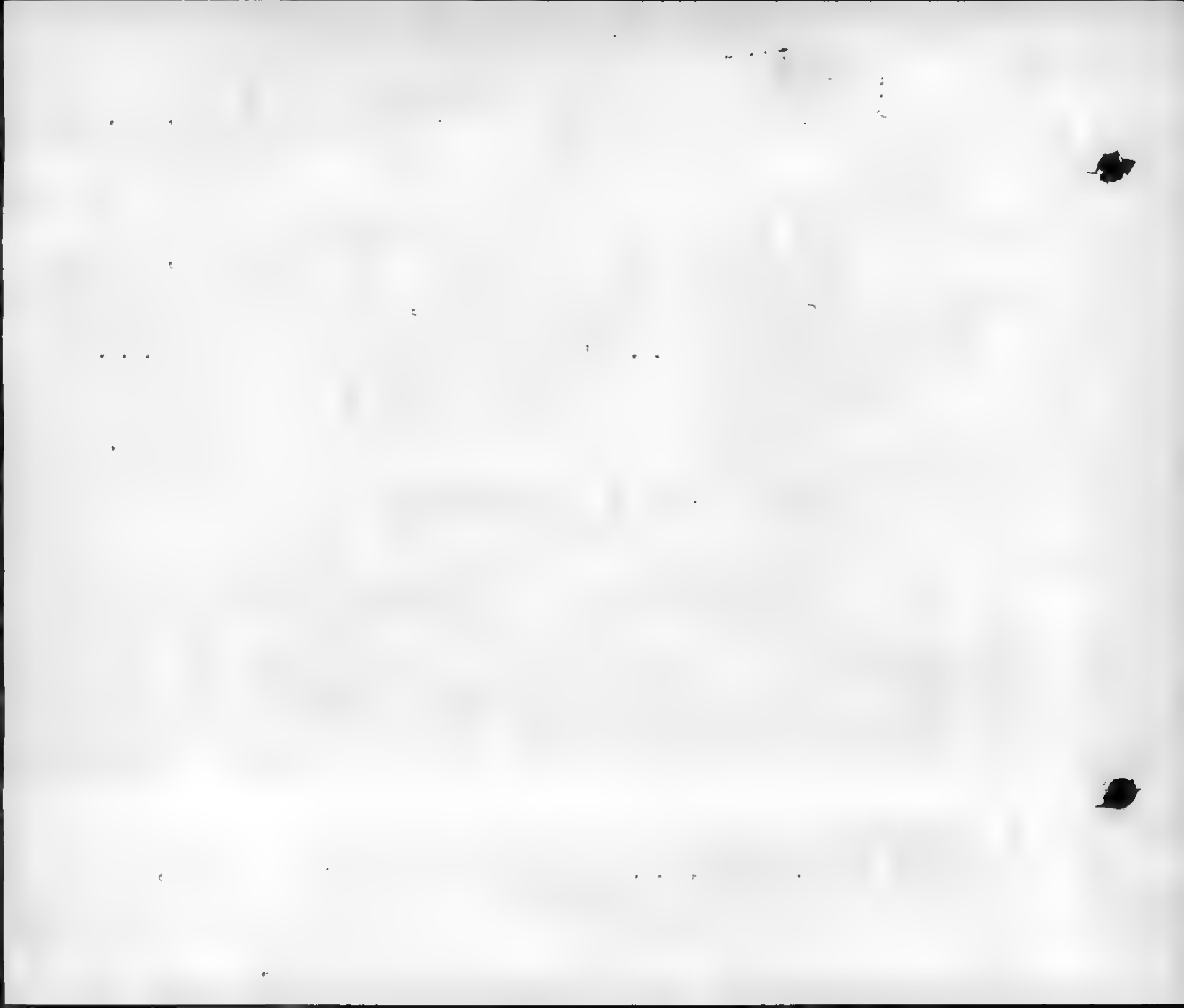
**7206**

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Tuxedo</b>				c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Tuxedo</b>			
c. LENGTH OF STAY IN 1b <b>4 years</b>				d. STREET ADDRESS <b>2410 57th Avenue</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>2410 57th Avenue</b>							
3. NAME OF DECEASED (Type or print) <b>Mary</b>		First <b>E</b> Middle <b>McConnell</b> Last		4. DATE OF DEATH <b>June 22, 1958</b>		Month <b>June</b> Day <b>22</b> Year <b>1958</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 1, 1905</b>	
9. AGE (In years last birthday) <b>53</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Louis McConnell; 3312 Manorwood Drive.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO (b) <b>Cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John T. Maloney</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>6/25/58</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL</b>		22d. LOCATION (City, town, or county) (State) <b>SUITLAND Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.E. FUNERAL HOME 300 4th ST. N.E.</b>				24a. REC'D BY REGISTRAR <b>DATE JUN 25 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Al. Beach</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7155

## CERTIFICATE OF DEATH

07172

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Prince George</b>		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 Day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brentwood</b>	
		d. STREET ADDRESS <b>4514 Banner Street</b>	
3. NAME OF DECEASED (Type or print) <b>Nelson</b>		4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>1958</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 16, 1900</b>
9 AGE (In years last birthday) yrs <b>57</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handyman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Beltsville Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Moore</b>		14. MOTHER'S MAIDEN NAME <b>Martha Braxton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service)	
17. INFORMANT <b>House Gilbert</b>		Address <b>4514 Banner St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage - internal capsule</b>			
450.0 DUE TO			
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.			
(b) <b>Arteriosclerosis generalized</b>			
DUE TO			
(c) <b>Congestive Heart Failure</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 19, 1958</b> to <b>June 20, 1958</b> that I last saw the deceased alive on <b>June 20, 1958</b> , and that death occurred at <b>11:35 PM</b> , from the causes and on the date stated above			
ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE <b>William Brainerd M.D.</b>		DATE SIGNED <b>6/25/58</b>	
PHYSICIAN'S NAME (Type) <b>Dr. W. Brainerd, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<b>6-24-58</b>		<b>Woodlawn</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Brimming Rd. St. DC.</b>		<b>DC.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry Washington</b>		ADDRESS <b>467 Nat. W.</b>	
24a. REC'D BY REGISTRAR <b>JUN 25 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alb. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 7156 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Laurel General Hospital</b>				d. STREET ADDRESS, <b>Box 428 Montgomery Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Nina</b>		First		Middle		Last	
4. DATE OF DEATH <b>June 26 19 58</b>		Month		Day		Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 17, 1897</b>		9. AGE (In years last birthday) <b>61</b> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph H. Moore</b>				14. MOTHER'S MAIDEN NAME <b>Ella Beall</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b>							<b>1 wk</b>
DUE TO (b) <b>Cerebral Hemorrhage</b>							<b>2 days</b>
DUE TO (c) <b>pyelonephritis</b>							<b>2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma Colon</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/16/58</b> , 19____, to <b>6/26/58</b> , 19____, that I last saw the deceased alive on <b>6/26/58</b> , 19____, and that death occurred at <b>5:45 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John M. Warren</b>				M.D. <b>305 Prince George Street, Laurel, Md.</b>			
PHYSICIAN'S NAME (Type)				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 29, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Layfield Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Laurel Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>De Witt Davidson</b>				ADDRESS <b>Laurel Md</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 3 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. Brown</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 715 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

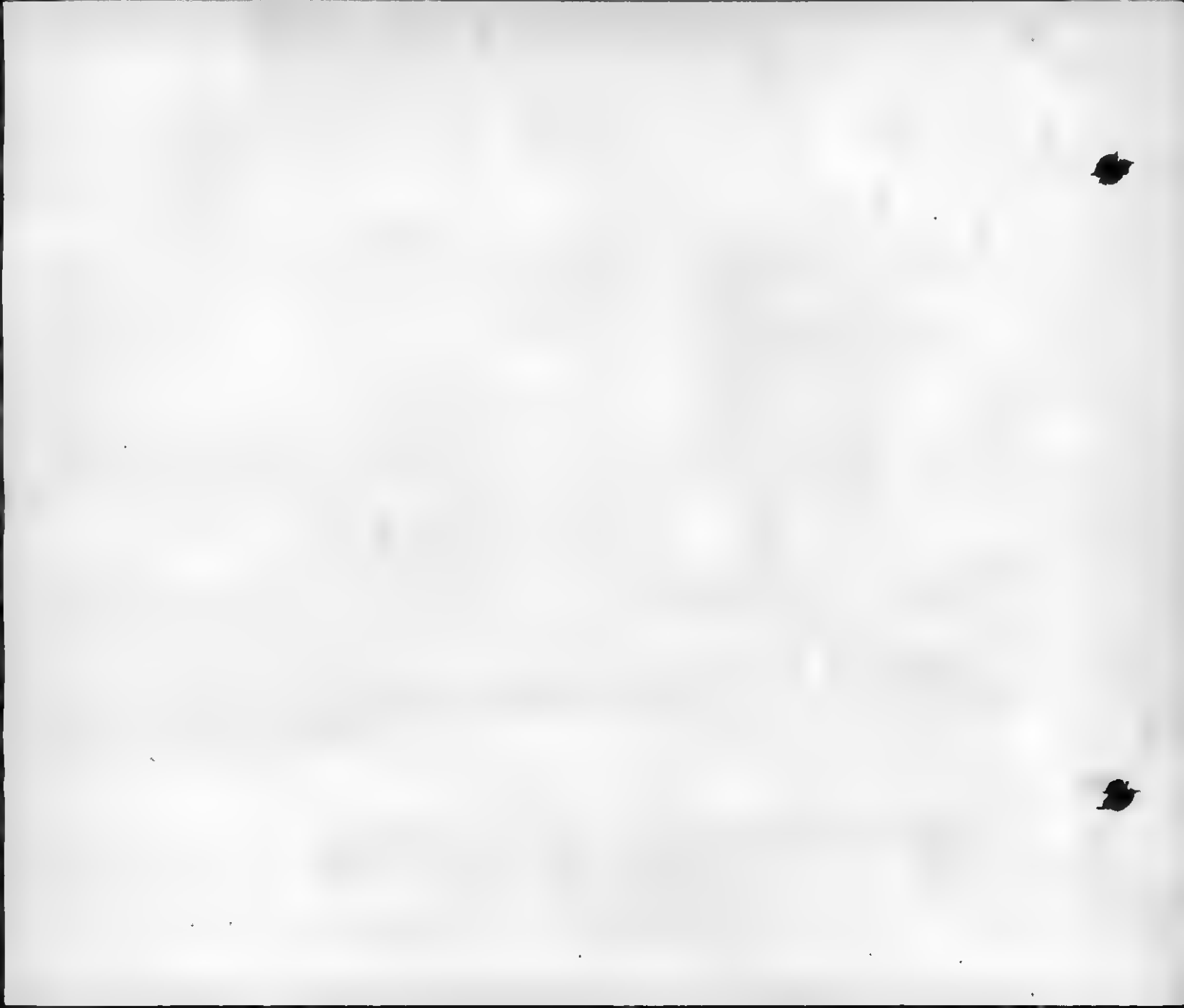
07174

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trinidad</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen. Hosp</u>		e. STREET ADDRESS <u>6113 - Kimbworth Ave</u>	
3. NAME OF (Type or print) <u>Katherine</u> <u>Maria</u> <u>Morningside</u>		4. DATE OF DEATH <u>June 21 - 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3-9-94</u> <u>64</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lawrence Helwig</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hahn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-10-7813</u>	
17. INFORMANT <u>Malcolm Johnson</u> <u>5405 Payhatten Rd. - Trinidad, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhage &amp; shock</u>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (b) <u>Crushed chest &amp; fractured skull</u>			
causing the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>A pedestrian struck by an automobile</u>	
20c. TIME OF INJURY Month, Day, Year <u>10-24-1957</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) (County) (State) <u>E. Prindle - P. Geo - Md</u>
21. I certify that I took charge of the remains described above, held or Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John T. Maloney</u>		DATE SIGNED <u>6-22-58</u>	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/24/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		24a. REC'D BY REGISTRAR <u>JUN 25 '58</u>	
ADDRESS <u>Hyattsville Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

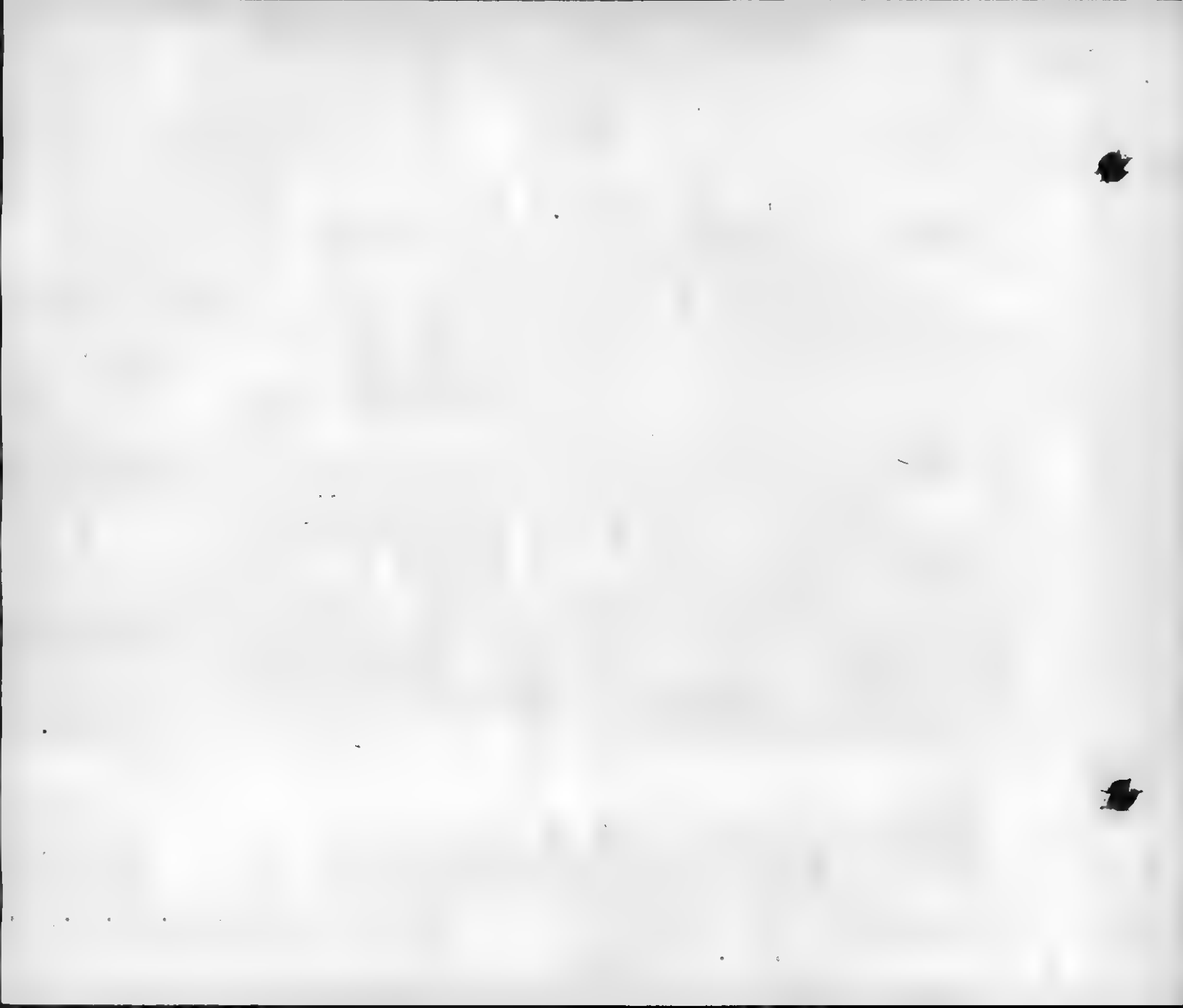
## 7158 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07175**

FOR STATE  
HEALTH DEPT.

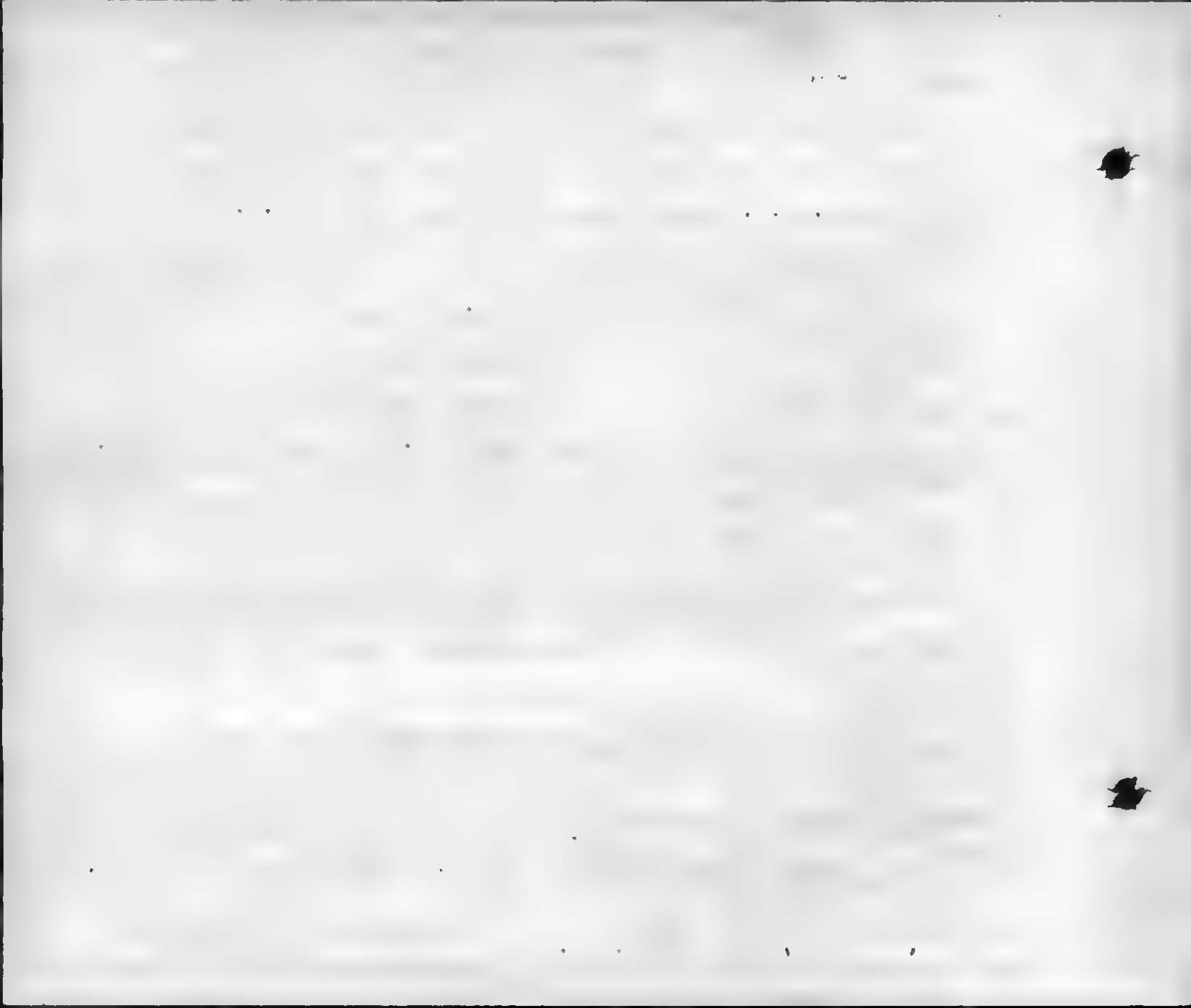
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hosp.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission.) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u> d. STREET ADDRESS <u>7601 Walter's Lane</u> e. IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Theodore Elridge Mullikin</u> First Middle Last <b>4. DATE OF DEATH</b> <u>June 9 1958</u> Month Day Year		<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>March 7, 1911</u> <b>9. AGE</b> (In years last birthday) <u>47 yrs</u> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Car repairman</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Washington terminal</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Elmer Randolph Mullikin</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Maude Whittington</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>719-01-3007</u> <b>17. INFORMANT</b> <u>Ruth Mullikin, same as # 2</u> Address		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Cerebral edema, toxic myocarditis</u> <u>104.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture of right tibia and fibula</u> (a), stating the underlying cause last, (c) <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) <u>Fell out of a tree</u> <b>20c. TIME OF INJURY</b> Month, Day, Year <u>6:45</u> <u>6/6/1958</u> Hour Minute <b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Yard of home</u> <b>20f. (City or town) (County) (State)</b> <u>Forestville P. G. Md.</u>		<b>21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>ACTUAL SIGNATURE</b> <u>James H. Boyd</u> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <u>James H. Boyd</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <u>James H. Boyd</u> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <u>June 10, 1958</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>6/13/1958</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln Cemetery</u> <b>22d. LOCATION</b> (City, town, or county) (State) <u>Colmar Manor, Pr. Geo. Co., Md.</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W.W. Chambers Co. Inc., Riverdale, Md.</u> <b>24a. RECORDING REGISTRAR'S SIGNATURE</b> <u>June 13 1958</u> <b>DATE</b> <b>24b. REGISTRAR'S SIGNATURE</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MEDICAL CERTIFICATION**

VS A15 (4)  
15M 9/55



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

Item 7, Film 7208 7/1/58.cac  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**CERTIFICATE OF DEATH**

07177

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived prior to institution, residence before admission) a. STATE <u>Dist. of Columbia</u> b. COUNTY <u>DC</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>none</u>		d. STREET ADDRESS <u>3213 9th Place, S.E. Washington, D.C.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ervin</u> Middle <u>Reuben</u> Last <u>Reed</u>		4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 20 1895</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (Tobacco) Own Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Am. U.S.A.</u>	
13. FATHER'S NAME <u>Charles Anna Reed</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>1918</u>		16. SOCIAL SECURITY NO. <u>578-54-9371</u>	
17. INFORMANT <u>Louis E. Schnoeble</u>		Address <u>3404 Wintergreen Ave., N. Forestville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Cardio-vascular and Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u> <u>yes</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour <u>6:30</u> p.m. <u>June</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 1955</u> to <u>June 10 1958</u> , that I last saw the deceased alive on <u>6-9 1958</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard S. Dobson</u> M.D.		ADDRESS (Street, city or town, state) <u>Bethesda, Md</u> DATE SIGNED <u>6/10/58</u>	
PHYSICIAN'S NAME (Type) <u>Richard S. Dobson</u>		<u>Bethesda Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/13/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Upper Marlboro, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 16 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Albert</u>	

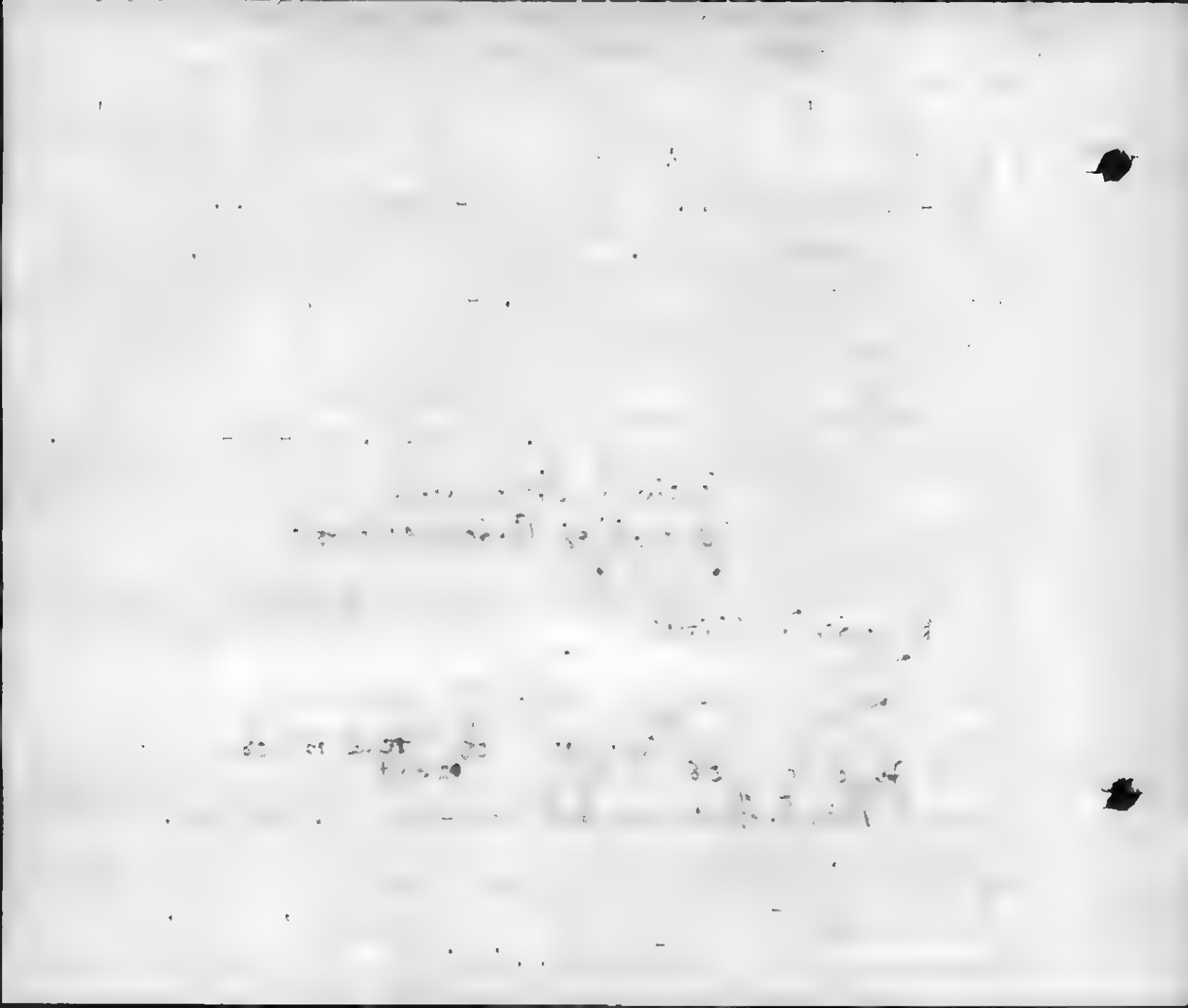


# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7209 CERTIFICATE OF DEATH

07178

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Geo's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxon Hill</b>				c. LENGTH OF STAY IN TB <b>44 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>5414- Livingston Road S.E.</b>				e. STREET ADDRESS <b>5414- Livingston Road S.E.</b>			
3. NAME OF DECEASED (Type or print) First <b>NICHOLAS</b> Middle <b>J.</b> Last <b>PETT</b>				4. DATE OF DEATH Month <b>June</b> Day <b>12th.</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 2- 1884</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Gardener</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
13. FATHER'S NAME <b>Hubert Pett</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
14. MOTHER'S MAIDEN NAME <b>Teresa Schrieber</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Elizabeth L. Pett -5414- Livingston RD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>May 11, 1958</b> to <b>June 12, 1958</b> , that I last saw the deceased alive on <b>June 10, 1958</b> , and that death occurred at <b>12:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Max E. Feldman M.D.</b>				ADDRESS (Street, city or town, state) <b>3800- South Cap. Street Wash., DC</b>			
DATE SIGNED <b>6/12/58</b>							
PHYSICIAN'S NAME (Type) <b>MAX E. FELDMAN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 14- 58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sammons Bros.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 16 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>	





07179

17459 **CERTIFICATE OF DEATH**

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Prince George</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Prince George</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Greenbelt</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Laurel</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Leland Memorial Hosp.</i>				STREET ADDRESS (If rural give location) <i>417 Laurel Ave.</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Harry Stellman Phelps</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>June 9 1958</i>			
<b>5. SEX</b> <i>M</i>		<b>6. COLOR OR RACE</b> <i>W</i>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>Divorced</i>		<b>8. DATE OF BIRTH</b> <i>January 15 1881</i>	
				<b>9. AGE last birthday</b> <i>77</i> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Mln.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Head clerk</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>B &amp; O Railroad</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Maryland</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>	
<b>13. FATHER'S NAME</b> <i>Edward Phelps</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Savilla Sewell</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>no</i> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <i>417 Laurel Ave. Mrs Elva Soper, Laurel, Md.</i>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <i>Myocardial Infarction</i>				INTERVAL BETWEEN ONSET AND DEATH <i>None</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Coronary Atherosclerosis</i>				<i>Raynaud's</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Myocardial Infarction</i>				<i>Chronic</i>			
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH</b> <i>Chronic Bronchial Asthma</i>				<i>Chronic</i>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State) <i>No Injury</i>			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <i>June 8, 1958</i> <b>to</b> <i>June 9, 1958</i> <b>that I last saw the deceased</b> <i>live on June 8, 1958</i> <b>and that death occurred</b> <i>June 9, 1958</i> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Harry J. Ford - M.D.</i>				<b>ADDRESS</b> (Street, city, town, state) <i>Laurel, Maryland</i> <b>DATE SIGNED</b> <i>June 9, 1958</i>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>Burial</i>		<b>DATE THEREOF</b> <i>June 11, 1958</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>Fry Hill Cemetery</i>		<b>LOCATION</b> (City, town, or county) <i>Laurel, Maryland</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>W. H. B. Borden, Jr.</i>		<b>ADDRESS</b>	
<b>DATE</b> <i>June 11, 1958</i>							

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy of the certificate should be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7159  
CERTIFICATE OF DEATH

Reg. Dist. No. 07180

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 111 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. STREET ADDRESS 6630 24th Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Lawrence W. Phelps		4. DATE OF DEATH Month Day Year June 20 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 Sept. 1896
9. AGE (In years last birthday) 61 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Phelps		14. MOTHER'S MAIDEN NAME Lila Woodworth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT Lawrence Phelps-6630 Riggs Manor, Htts. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Carcinoma of Esophagus</i> 150x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/30/58 19 to 6/20/58 19, that I last saw the deceased alive on 6/17/58 19, and that death occurred at 5.00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>George William Ware</i> M D NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 6-23-58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Wash. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Timothy Naylor</i>		24a. REC'D BY REGISTRAR JUN 23 58 DATE	
ADDRESS 3831 GA Av.		24b. REGISTRAR'S SIGNATURE <i>W. E. Enoch</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

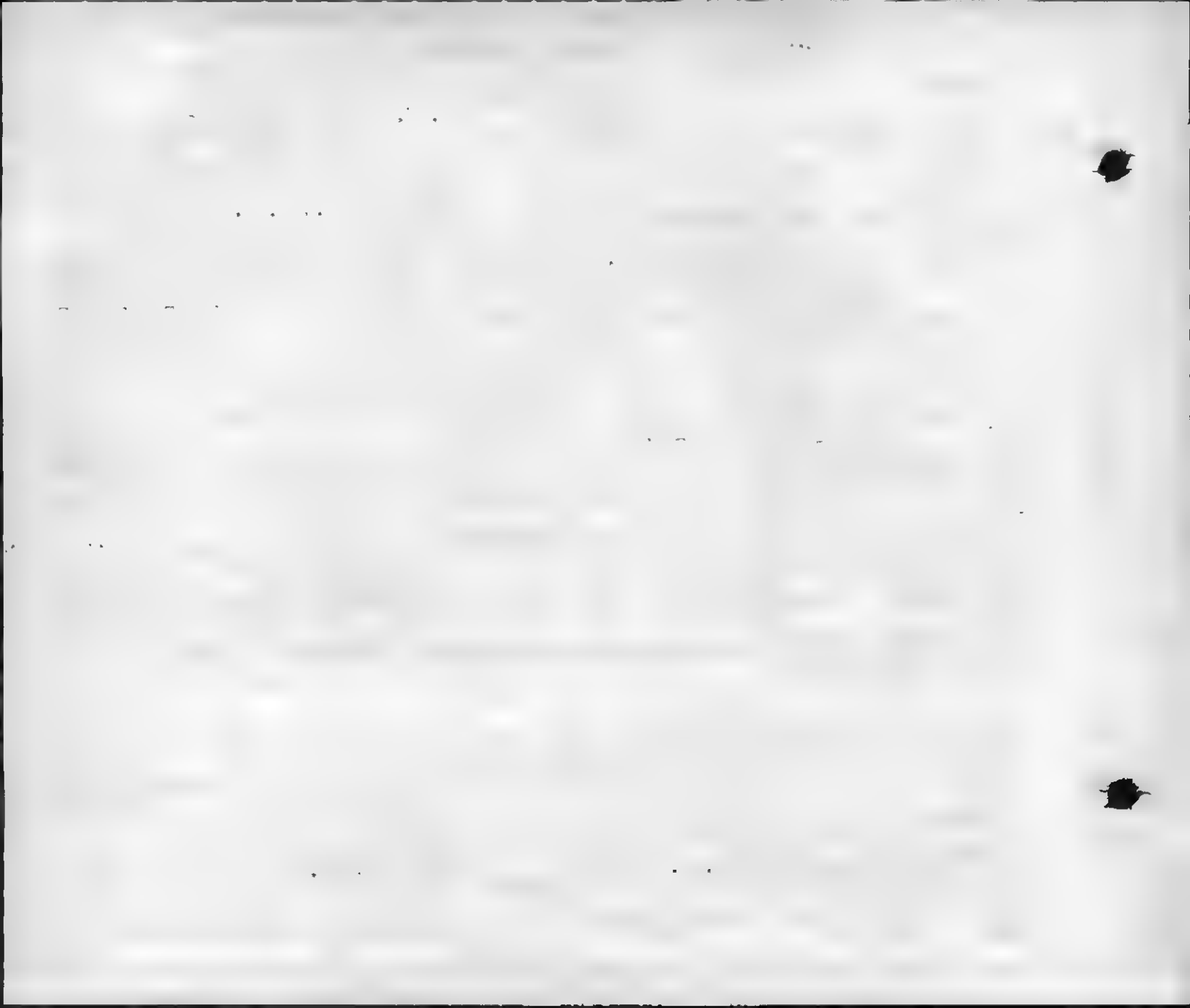
7210

## CERTIFICATE OF DEATH

Reg. Dist. No.

07181

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>-</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
c. LENGTH OF STAY IN 1b <b>1 month and 29 days</b>				d. STREET ADDRESS <b>1417 9th St., N. W.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Theodore</b> Middle <b>J.</b> Last <b>Pollard</b>			4. DATE OF DEATH Month <b>6</b> Day <b>19</b> Year <b>19 58</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>Separated (not legally)</b>	8. DATE OF BIRTH <b>2/27/21</b>		9. AGE (In years last birthday) <b>37</b> yrs.	IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Jessie Bradford</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Pollard</b>				14. MOTHER'S MAIDEN NAME <b>Ella Dade</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1943 - 1945, 579-12-2878</b>		17. INFORMANT <b>Decedent</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary tuberculosis</b> DUE TO (c) <b>Cor pulmonale</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b> <b>5 yrs., 9 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cor pulmonale</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <b>o. n.</b> Month, <b>19</b> Day, <b>19</b> Year p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4/21</b> , 19 <b>58</b> , to <b>6/19</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6/19</b> , 19 <b>58</b> , and that death occurred at <b>11:58 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Glenn Dale Hospital</b> DATE SIGNED <b>6/19/58</b> ACTUAL SIGNATURE <b>Moe Weiss</b> M.D. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b> <b>Glenn Dale, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/24/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Rhines</b>				24a. REC'D BY REGISTRAR <b>W. C. License # 318</b>		24b. REGISTRAR'S SIGNATURE <b>W. C. License # 318</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7160

## CERTIFICATE OF DEATH

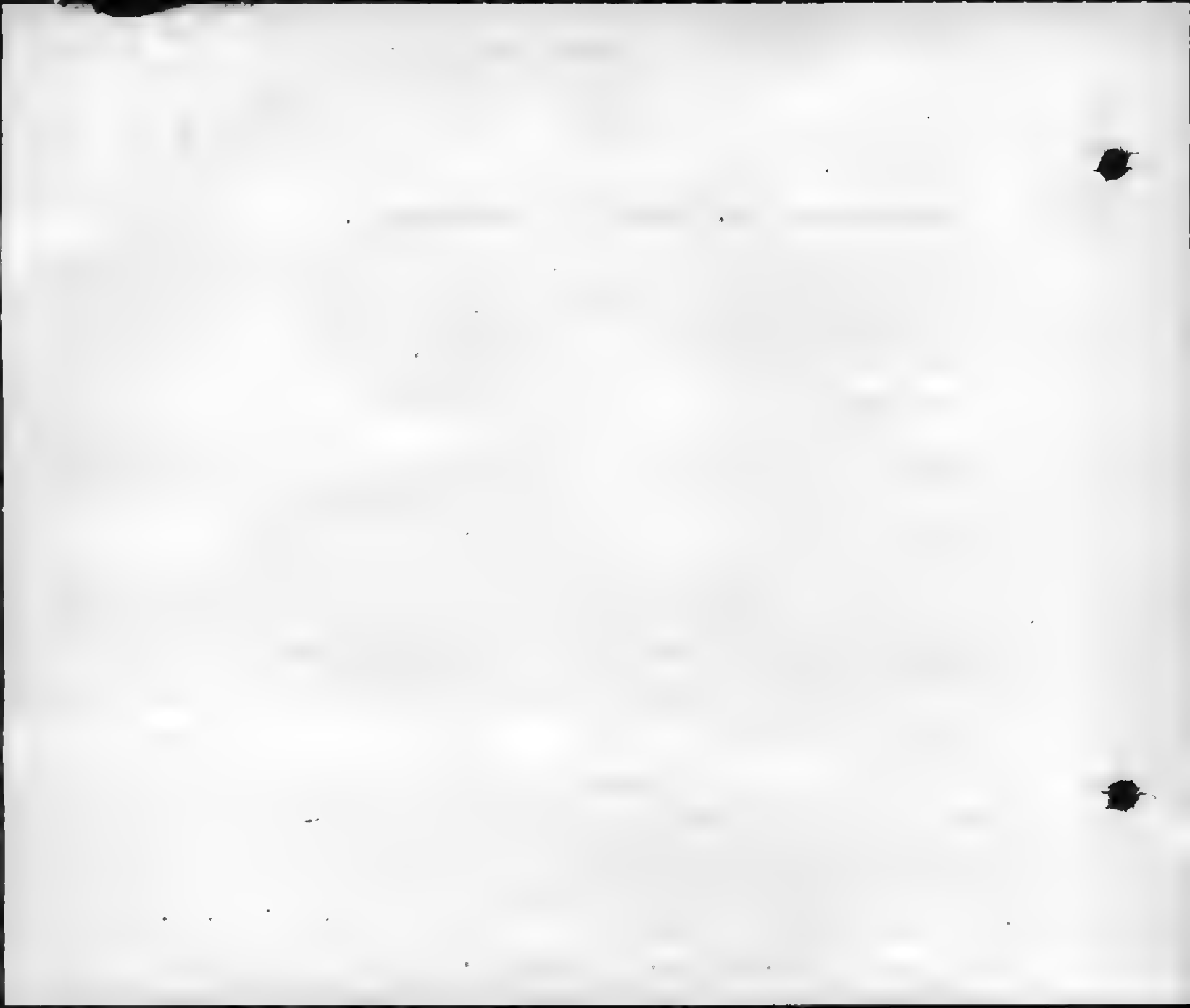
07182

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly Md.</b> c. LENGTH OF STAY IN 1b <b>14</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b> d. STREET ADDRESS <b>4802 Navahoe St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby Boy Potts</b> First Middle Last		4. DATE OF DEATH Month Day Year <b>June 9 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-9-58</b>
9. AGE (In years last birthday) yrs <b>9 35</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>9 35</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Frank Potts</b>		14. MOTHER'S MAIDEN NAME <b>Leona Potts</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Mother</b>		Address <b>as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>762.5</b> DUE TO <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/9/1958</b> to <b>6/9/1958</b> , that I last saw the deceased alive on <b>6/9/1958</b> and that death occurred at <b>11:55A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5301 Hawthorne St., N. 4th, E/10</b> DATE SIGNED ACTUAL SIGNATURE <b>John W. Perkins</b> M.D. PHYSICIAN'S NAME (Type) <b>John W. Perkins</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>6/12/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr., Administrator</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 18 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Alb. Beach</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7211

## CERTIFICATE OF DEATH

Reg. Dist. No.

07183

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL LAUREL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL LAUREL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>STANDY SPRINT ROAD</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>CHARLES</u> First <u>ELMER</u> Middle <u>PRITCHARD</u> Last				4. DATE OF DEATH <u>JUNE</u> Month <u>7</u> Day <u>1958</u> Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 2, 1886</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES ALBERT PRITCHARD</u>				14. MOTHER'S MAIDEN NAME <u>SARAH GARRISON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-05-7189</u>		17. INFORMANT <u>WIFE - HELEN E. PRITCHARD - SAME ADDRESS.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED CARCINOMATOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF PANCREAS</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>6 WEEKS</u> <u>6 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerosis, Residual of cerebral Thrombosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January</u> , 19 <u>55</u> , to <u>JUNE 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>JUNE 2</u> , 19 <u>58</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. R. Buell</u>				ADDRESS (Street, city or town, state), DATE SIGNED <u>402 Main St - Laurel Md 6/7/58</u>			
PHYSICIAN'S NAME (Type) <u>JOHN R. BUELL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial June 10, 1958</u>		<u>June 10, 1958</u>		<u>St. Paul Cem.</u>		<u>Laurel Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Alfred Donaldson</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 16 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. Brown</u>	



7212

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi Syattsville Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2360 Carl Spring Road</u>		d. STREET ADDRESS <u>2360 Carl Spring Road</u>	
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>J.</u> Last <u>REED</u>		4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7-1869</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Not Available</u>	
14. MOTHER'S MAIDEN NAME <u>Not Available</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Lawrence E. Reed</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u>		<u>Few hours.</u>
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
(b) <u>Cardio-Vascular-Renal Disease</u>		<u>5 yrs.</u>
DUE TO		
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITIONS GIVEN IN PART I				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
NOTE: The deceased was found pronounced dead by a nearby physician in state after noon.				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, item 18.)	20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that I attended the deceased from <u>Sept. 30, 1953</u> to <u>June 11, 1958</u> that I last saw the deceased alive on <u>June 3, 1958</u> , and that death occurred at <u>2360 Carl Spring Road</u> , M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE <u>Edward Heyes</u>		M.D. <u>LYNN D. HICKS M.D. F.A.C.P.</u>		
PHYSICIAN'S NAME (Type)		6040 Phoebe Road, N. W.		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		
<u>BURIAL</u>		<u>June 13, 1958</u>		
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)		
<u>Forest Hill Cemetery</u>		<u>Prince George Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR		
<u>Arthur H. Hatter</u>		DATE <u>JUN 13 '58</u>		
ADDRESS <u>254 Carroll St - D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur H. Hatter</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

George Jackson  
George Jackson - known to me  
to know

NOTE: The above information is for  
the purpose of identifying the  
person who is the subject of the  
investigation. It is not to be  
used for any other purpose.  
X

28-11-72  
28-11-72

28-11-72  
28-11-72

28-11-72

7161

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rivindale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leeland Memorial Hosp</u>				d. STREET ADDRESS <u>4408 Queensbury Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Edward Baublitz Reier</u>				4. DATE OF DEATH <u>June 7 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-25-07</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired printer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Govt. Print. Off. Washington, D.C.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Geo. Edu. Reier</u>				14. MOTHER'S MAIDEN NAME <u>Laura Baublitz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give way or dates of service) <u>World War II 1944-45</u>				16. SOCIAL SECURITY NO. <u>514-32-8826</u>			
17. INFORMANT <u>Betty Reier</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>330 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Aneurysm of cerebral artery</u> DUE TO (c) <u>50 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>minutes (congenital)</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary edema</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6-4-58</u> , 19 <u>58</u> , to <u>6-7-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-7-58</u> , 19 <u>58</u> , and that death occurred at <u>5:40 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4404 Queensbury Rd Rivindale Md</u> DATE SIGNED <u>6-7-58</u>							
ACTUAL SIGNATURE <u>D. R. Purdie</u> M.D.				PHYSICIAN'S NAME (Type) <u>D. R. Purdie</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-10-1958</u>		<u>Arlington National</u>		<u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home Inc Mt Rainier</u>				24. REC'D BY REGISTRAR <u>W. Beach</u>			
ADDRESS <u>Md.</u>				DATE <u>JUN 11 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4

may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for filing. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2.57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

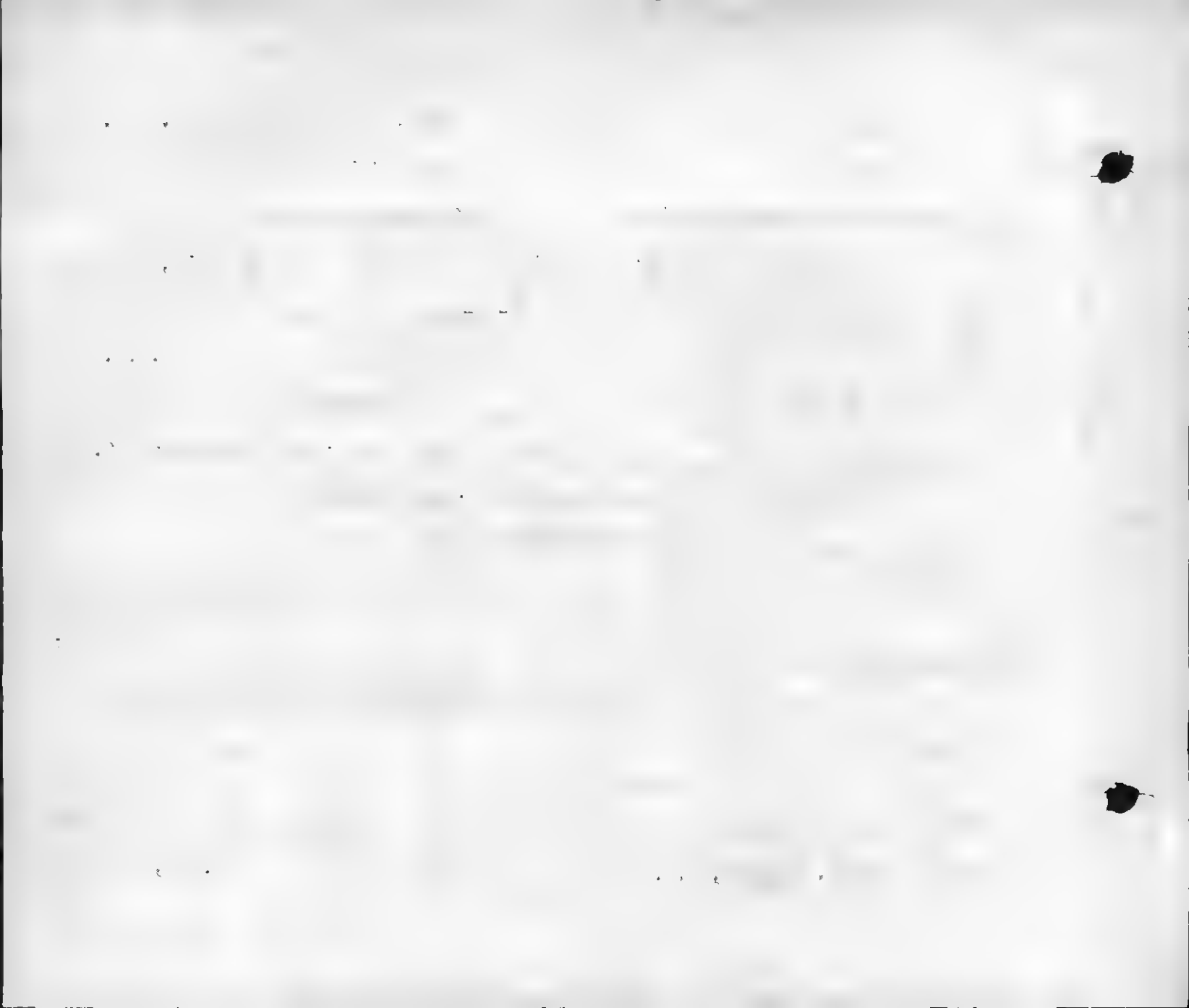
07187

7162 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheserly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>4206 Decatur Street</b>	
3. NAME OF DECEASED (Type or print) <b>Alice Witmer Rice</b>		4. DATE <b>June 14, 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-12-1875</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>New York State</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Martin Witmer</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth King</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Margery Cunningham; same address as #2.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular renal disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m p m 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>June 14, 1958</b>	
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>6/16/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Port Lincoln Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Maryland.</b>	
24a. REC'D BY REGISTRAR <b>JUN 16 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Schuch</b>	

2





FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07188

7163

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 4, Film 230 6-26-58 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>4552 41 st. Ave./</b>	
3. NAME OF DECEASED (Type or print) <b>MARGARET</b>		4. DATE OF DEATH Month <b>June</b> Day <b>18</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 Oct. 1909</b>
9. AGE (In years last birthday) <b>48</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Mockabee</b>		14. MOTHER'S MAIDEN NAME <b>Martha Hawkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Lionel Boswell;</b>		Address <b>same address as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>7</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>June 18, 1958</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>6-21-58</b>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	22d. LOCATION (City, town, or county) (State) <b>Wash. D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Maloney</b>		24a. REC'D BY REGISTRAR <b>498</b>	24b. REGISTRAR'S SIGNATURE <b>498</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7164 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07189

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a STATE D.C. b COUNTY Washington	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chiverlay		c LENGTH OF STAY IN 1b D.O.A.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges Gen. Hosp		d STREET ADDRESS 4613 Sargeant Rd. N.E.	
3 NAME OF DECEASED (Type or print) Nelson Francis Rodgers		4 DATE OF DEATH 6-21-1958	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 9-5-19
9 AGE (In years last birthday) 38 yrs		10 IF UNDER 1 YEAR Months Days	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		12 CITIZEN OF WHAT COUNTRY? U.S.G.	
13 FATHER'S NAME Fitch Hugh T Rodgers		14 MOTHER'S MAIDEN NAME Annie White	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes W.W. 2		16 SOCIAL SECURITY NO. W.W. 2	
17 INFORMANT Catherine Rodgers - Sanham, Md		18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b) Cardiovascular renal disease			
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED June 22, 1958	
EXAMINER'S NAME (Type) JOHN T. MALONEY		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/25/58	
22c. NAME OF CEMETERY OR REMOVAL ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) Arlington Virginia, (State)	
23 FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Maryland.		24a REC'D BY REGISTRAR JUN 25 '58	
ADDRESS		24b REGISTRAR'S SIGNATURE	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07190

7165

Reg. Dist. No.

FOR STATE HEALTH DEPT.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u> c. LENGTH OF STAY IN 1b <u>2-0-0</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's Hosp.</u> e. STREET ADDRESS <u>5014-16th Street</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If inst. lullon: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glassman</u> d. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) <u>Paul Joseph Rozinski</u>		<b>4. DATE OF DEATH</b> June 14- 1958		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>7-4-1907</u>		<b>9. AGE</b> (In years last birthday) <u>50</u> yrs		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min		<b>11. IF UNDER 24 HRS</b> Months Days Hours Min	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Staff manager</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Insurance</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Washington DC</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>					
<b>13. FATHER'S NAME</b> <u>Natimillian Rozinski</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Anna Stelmick</u>											
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unknown) (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>577-07-2100</u>				<b>17. INFORMANT</b> <u>Guarantor Rozinski - Same address</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>12X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular renal disease</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a m p m 19				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></b>																	
<b>ACTUAL SIGNATURE</b> <u>John T. Maloney</u>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b>									
<b>EXAMINER'S NAME (Type)</b> <u>JOHN T. MALONEY, M.D.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>June 14, 1958</u>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>6/18/58</u>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Glenwood Cemetery</u>				<b>22d. LOCATION (City, town, or county)</b> (State) <u>Washington D.C.</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Frank Siers Sons Co</u>								<b>ADDRESS</b> <u>3605-14 St NW</u>				<b>24a. REC'D BY REGISTRAR</b> <u>JUN 17 '58</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>W. Search</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please  
execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page  
4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7166 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07191

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Riverdale, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 6200 54th Place,.	
3 NAME OF DECEASED (Type or print) MILTON MILLER ROUZEE		4. DATE OF DEATH June 7, 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 14, 1907
9. AGE (In years last birthday) 50 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur American Red Cross	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert Rouzee		14. MOTHER'S MAIDEN NAME Emma Repetti	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Geraldine M Rouzee		Address East Riverdale, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive Heart Failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiovascular renal disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John T. Maloney</i> EXAMINER'S NAME (Type)		DATE SIGNED June 7, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/9/58	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR JUN 11 '58	
ADDRESS Hyattsville, Maryland.		24b. REGISTRAR'S SIGNATURE <i>W. H. Beach</i>	

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11

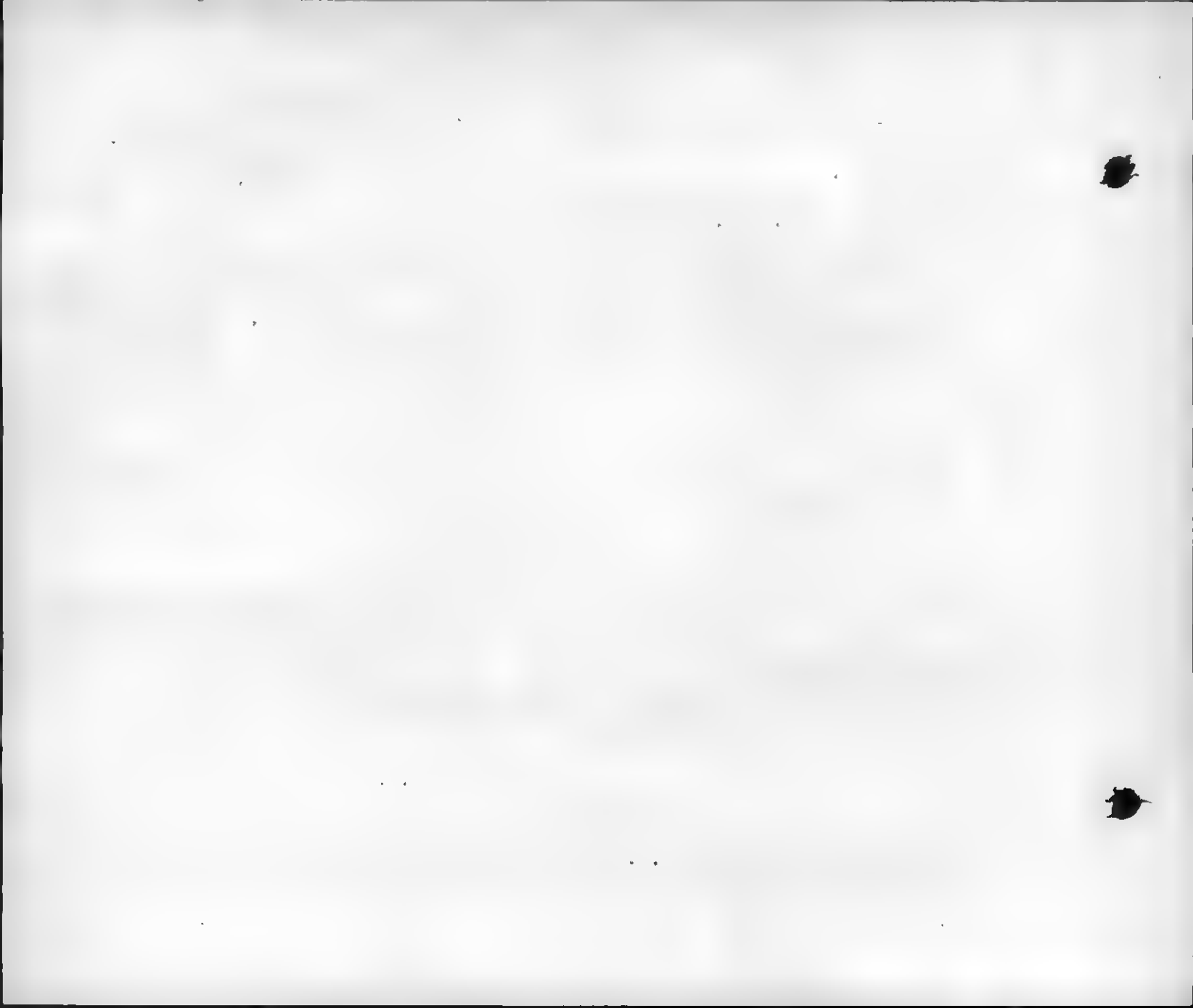
## CERTIFICATE OF DEATH

07192

7167

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Box 60 Hillmeade, Bowie, Md</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Maryland Prince Geo. Gen. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marcus Sanders</b>		4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/17/58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <b>3 wks.</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Cheverly, Maryland</b>	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		14. MOTHER'S MAIDEN NAME <b>Geraldine Sanders</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia Rt. Side</b> <b>763.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 5, 1958</b> , to <b>June 6, 1958</b> , that I last saw the deceased alive on <b>June 6, 1958</b> , and that death occurred at <b>3 P.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>300 Cheverly Ave, Cheverly Md 20858</b> DATE SIGNED <b>June 6, 1958</b>			
ACTUAL SIGNATURE <b>Bertha VanGilder M.D.</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. RECEIVED BY REGISTRAR DATE <b>JUN 18 '58</b>
			24b. REGISTRAR'S SIGNATURE



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7213 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07193

Reg. Dist. No.

1  
FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) o STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Silesia</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silesia</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8210 Indian Head Highway</u>		e. STREET ADDRESS <u>8210 Indian Head Highway</u>	
3. NAME OF DECEASED (Type or print) <u>Hester</u> First <u>Ann</u> Middle <u>Scott</u>		4. DATE OF DEATH <u>June 16</u> 19 <u>58</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 18, 1896</u> 62 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Run Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>William Houns</u>		14. MOTHER'S MAIDEN NAME <u>Olivia Garner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>111-11-1111</u>	
17. INFORMANT <u>Lillian Haveren, same as #</u> Address <u>same as #</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>June 16, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 18-58</u>		22b. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	
22c. LOCATION (City, town, or county) <u>Southland Md</u>		22d. (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sumner Bros</u> ADDRESS <u>1661-9th Hoped Rd</u>		24a. REC'D BY REGISTRAR <u>Wash DC SE</u>	
24b. REGISTRAR'S SIGNATURE <u>Wash DC SE</u>		DATE <u>JUN 17 '58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07194

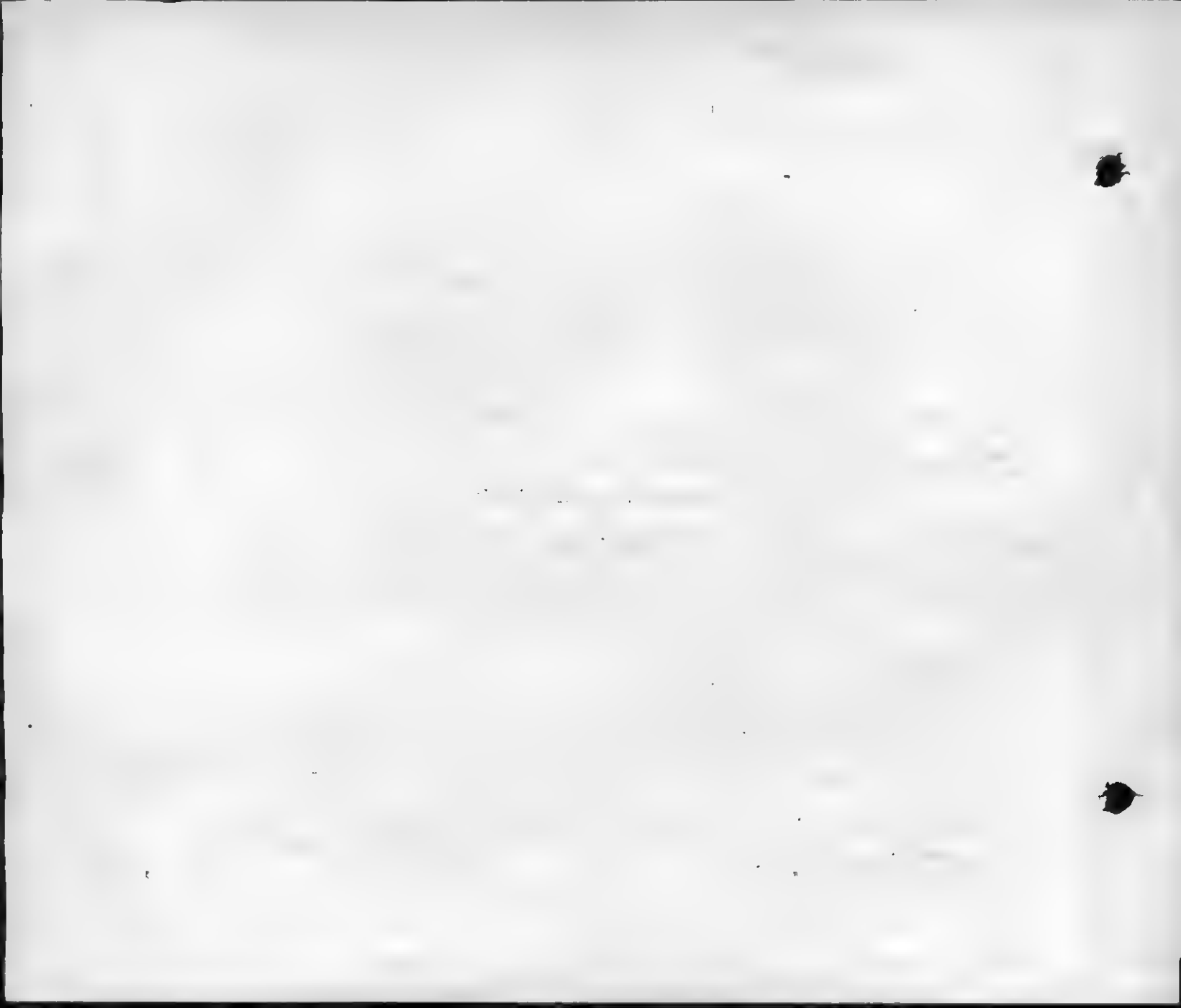
7214

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (and give nearest town) Meadows		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Meadows	
c. LENGTH OF STAY IN 1b 7 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 1, Box 164		f. STREET ADDRESS Route # 1, Box 164	
3. NAME OF DECEASED (Type or print) Dorothy Ann Seis		4. DATE OF DEATH Month June Day 8 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1932
		9. AGE (In years last birthday) 26 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Radtke		14. MOTHER'S MAIDEN NAME Nellie Vermillion	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. XXXXX	
17. INFORMANT Mrs Nellie Radtke, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock			
DUE TO (b) Shot gun wounds of the chest			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot during an altercation	
20c. TIME OF INJURY Month, Day, Year 1:45 p.m. 6/ 8 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Yard of home		20f. (City or town) Meadows (County) P. G. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 11-58 Euphony		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Mountville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
ADDRESS 1661-gard Hope Rd SE		24b. REGISTRAR'S SIGNATURE	
DATE JUN 10 '58			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

STATE OF HEALTH—BALTIMORE, 18									
Items 8 & 9 Film G-231 7/10/58									
7215 CERTIFICATE OF DEATH									
Reg. Dist. No. 07195									
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Old.</u> b. COUNTY <u>Prince Georges</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u>			c. LENGTH OF STAY IN 1b <u>2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Virgie</u> Middle <u>E</u> Last <u>Shaw</u>					4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1958</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1879</u> <u>April 22, 1879</u>		9. AGE (In years last birthday) <u>79</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Robert Robey</u>					14. MOTHER'S MAIDEN NAME <u>Sarah ?</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-01-8382</u>		17. INFORMANT <u>Edna B. Cross, Brandywine, Old.</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>H. d. d. d.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>May</u> , 19 <u>57</u> , to <u>June 22, 1958</u> , that I last saw the deceased alive on <u>19 58</u> , and that death occurred at <u>5 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Indian Head Old</u> DATE SIGNED <u>6/23/58</u> ACTUAL SIGNATURE <u>Frank A. Susan</u> M.D. PHYSICIAN'S NAME (Type) <u>Frank A. Susan M.D.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Pauls Pines</u>			22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home, Waldorf, Md.</u>					24a. REC'D BY REGISTRAR DATE <u>JUN 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>		





## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN TB <b>22 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eugene Leland Memorial Hospital</b>						d. STREET ADDRESS <b>4501 Queensbury Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>REBA</b>		Middle <b>I.</b>		Last <b>SHORT</b>		4. DATE OF DEATH Month <b>June</b>		Day <b>27</b>		Year <b>1958</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 5, 1911</b>		9. AGE (In years last birthday) <b>46 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William L. Peterson</b>						14. MOTHER'S MAIDEN NAME <b>Lella D. Hall</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Hospital Records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Edema of Congestion</b> <b>420.0</b> DUE TO (b) <b>Arteriosclerotic Heart disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of the liver, Bilephitis</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>June 4</b> , 19 <b>58</b> , to <b>June 27</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6-27</b> , 19 <b>58</b> , and that death occurred at <b>2:30</b> A.M., from the causes and on the date stated above.											
ACTUAL SIGNATURE <b>R. R. Purdie</b>				ADDRESS (Street, city or town, state) <b>Riverdale Md</b>				DATE SIGNED <b>June 27, 1958</b>			
PHYSICIAN'S NAME (Type) <b>D R Purdie</b>				Riverdale Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 30, 1958</b>		22c. NAME OF CEMETERY OR <del>CREMATOR</del> <b>Fort Lincoln Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>						ADDRESS <b>Hyattsville Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 30 '58</b>		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7169

## CERTIFICATE OF DEATH

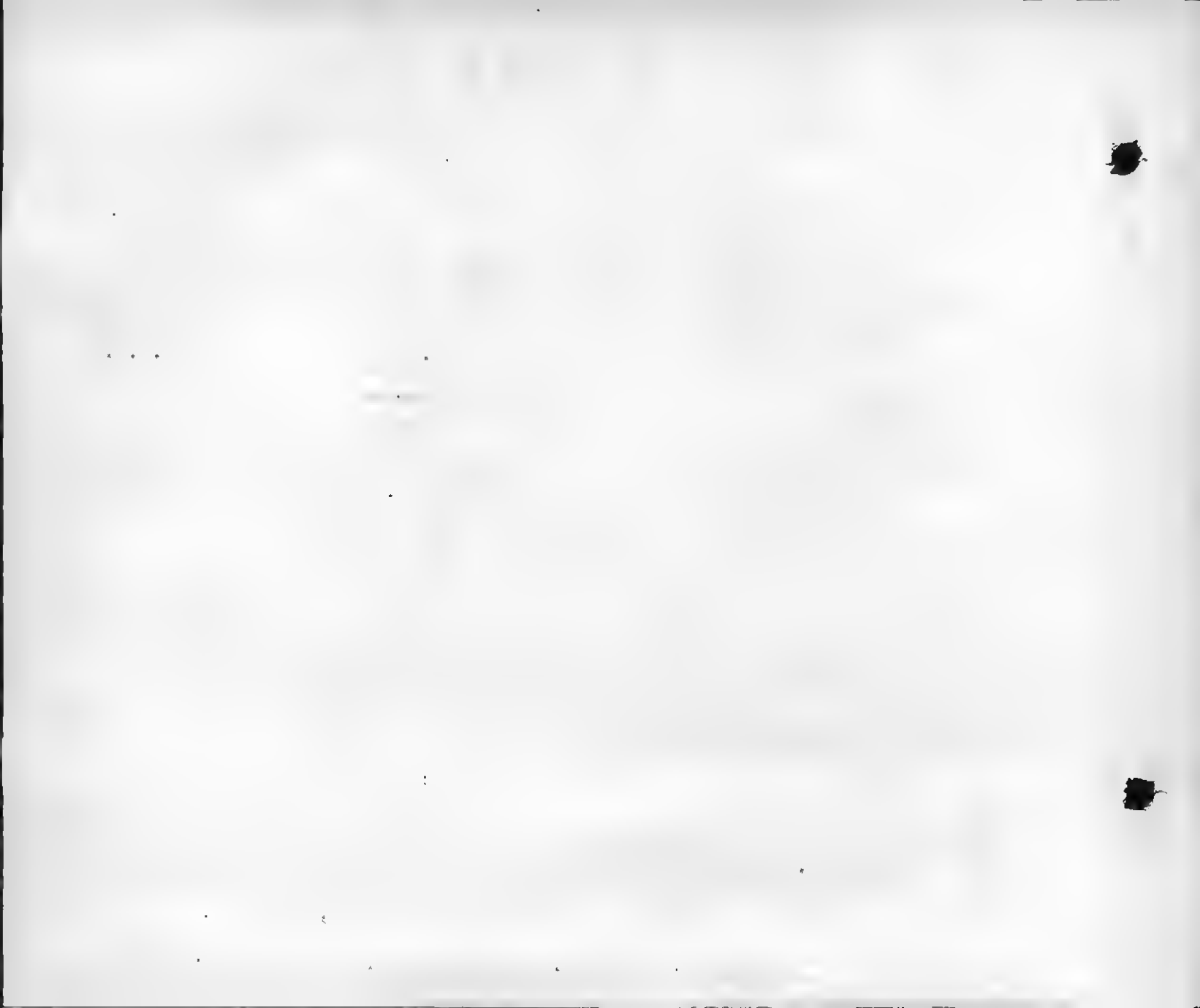
07197

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		b. MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>4 Hrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westwood</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby Girl Simms</b>			4. DATE OF DEATH Month Day Year <b>6 9 19 58</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-9-58</b>		9. AGE (In years last birthday) yrs. <b>10</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>10 50</b>	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Catherine Simms</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>16d.2 DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <b>Diabetes</b> <b>Pneumonia</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/9/58</b> , 19 <b>58</b> , to <b>6/9/58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6/9/58</b> , 19 <b>58</b> , and that death occurred at <b>10:50 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John W. Perkins</b>		M. D. <b>5301 Hawthorn St. Hyattsville Md 6/10</b>		ADDRESS (Street, city or town, state)		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>John W. Perkins</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>6/12/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr., Admin</b>		ADDRESS <b>18 '58</b>		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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7170

## CERTIFICATE OF DEATH

07198

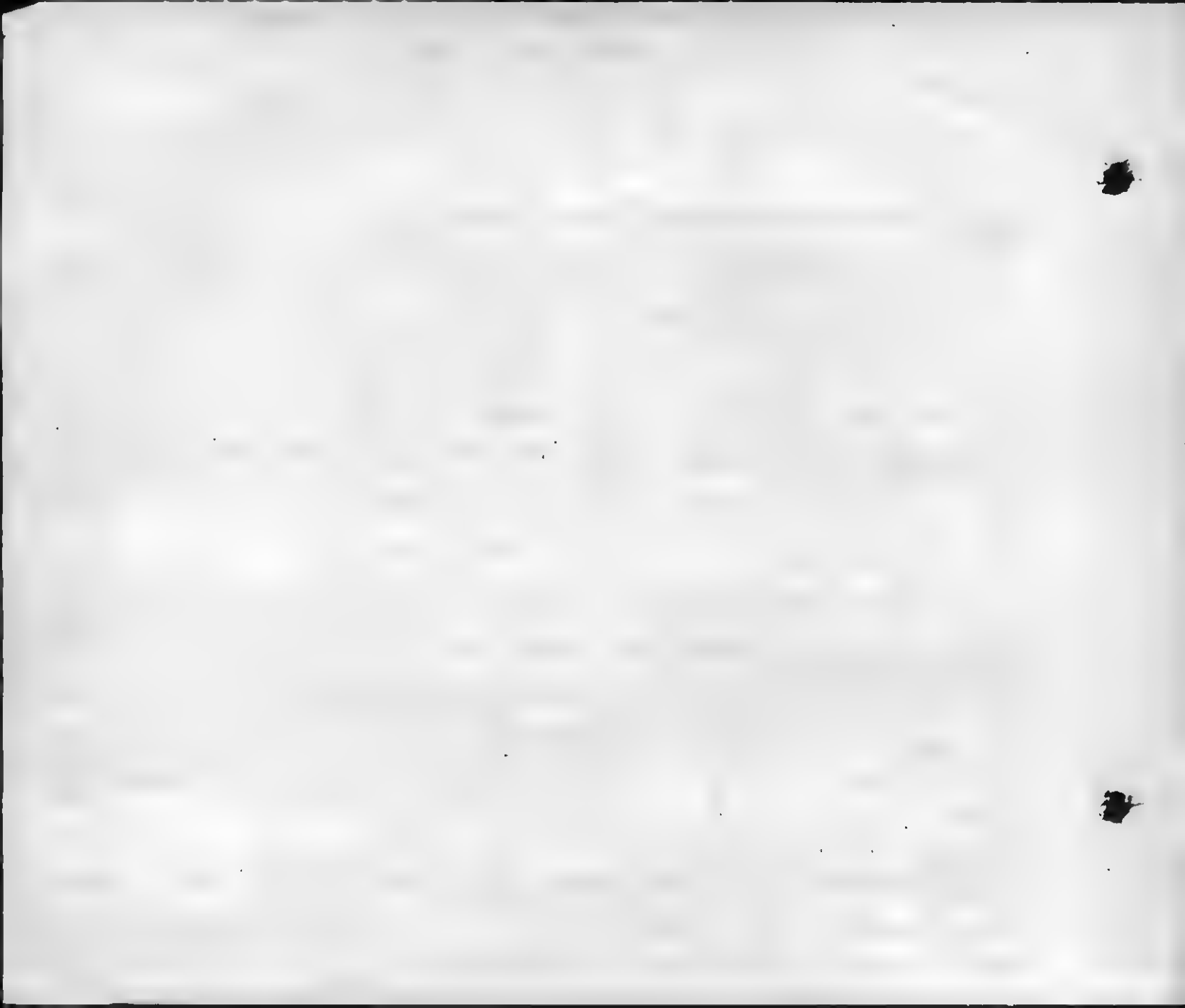
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. LENGTH OF STAY IN 1b <u>3 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Baltimore Zoo and Hotel</u>				d. STREET ADDRESS <u>6166 Rutledge Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>CHARLES ANTHONY SIMPSON</u>				4. DATE OF DEATH <u>June 26 1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 29, 1914</u>		9. AGE (In years last birthday) <u>43</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cable Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baking</u>		11. BIRTHPLACE (State or foreign country) <u>Capitol Heights Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John - Simpson</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-05-1308</u>		17. INFORMANT <u>Mrs. Charles Simpson</u> Address <u>6166 Rutledge Rd, D Forest Hill</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphosarcoma</u>							<u>20 months</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____							
(c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/22/56</u> to <u>6/26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 26</u> , 19 <u>58</u> , and that death occurred at <u>home</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Brainin</u> M.D.				ADDRESS (Street, city or town, state) <u>6124 Central Ave</u>		DATE SIGNED <u>6/26/58</u>	
PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>				Capitol Heights Md			
22a. BURIAL, CREMATION, REINTERMENT (Specify) <u>6/30/58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland - Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm Lee's Sons Co</u>				ADDRESS <u>300 4TH ST. SE</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 30 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>			

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7171

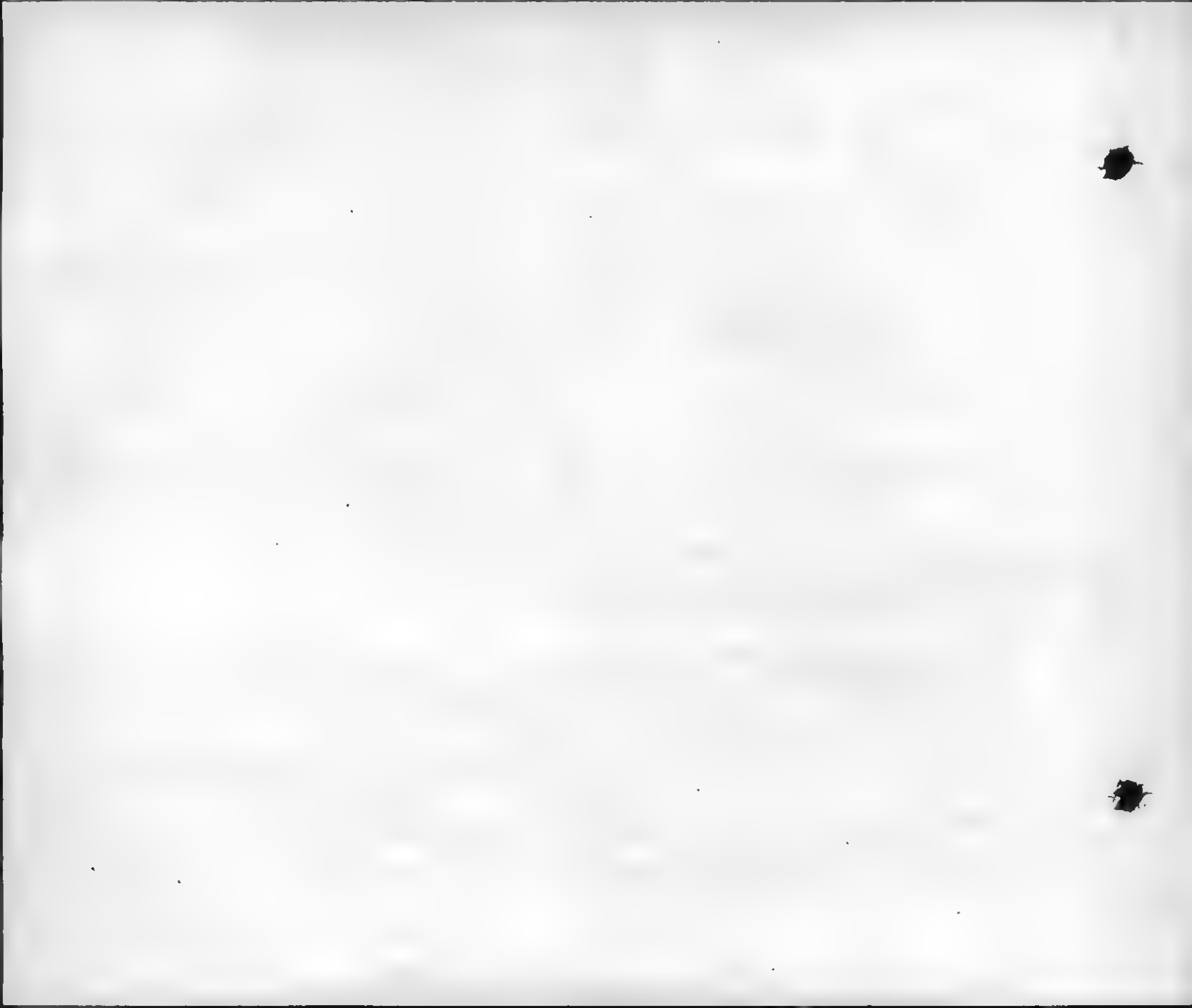
CERTIFICATE OF DEATH

07199

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cherry</b>		c. LENGTH OF STAY IN 1b <b>4 hrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Nancy Baby</b> First <b>Jane</b> Middle <b>Girl</b> Last <b>Smart</b>		4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>14 June 58</b>
9. AGE (In years last birthday) yrs. <b>4</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>14</b>	11. IF UNDER 24 HRS Hours <b>4</b> Min <b>19</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>None</b>	
13. FATHER'S NAME <b>Clare Smart</b>		14. MOTHER'S MAIDEN NAME <b>Dorothea Veale</b>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital records</b>		Address <b>Hospital records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>760.0</b> DUE TO <b>Intra cranial hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Raceration R the Rt tentorium cerebelli</b> (c) <b>None</b>		INTERVAL BETWEEN ONSET AND DEATH <b>None</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State) <b>None</b>	
21. I certify that I attended the deceased from <b>14 June 1958</b> to <b>14 June 1958</b> , that I last saw the deceased alive on <b>14 June 1958</b> , and that death occurred at <b>5:20 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Joseph J. McDonald</b>		DATE SIGNED <b>6/14/58</b>	
PHYSICIAN'S NAME (Type) <b>DR. J. McDONALD, MD.</b>		ADDRESS (Street, city or town, state) <b>7309 RIGGS RD. W. HYATTSVILLE, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/17/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley's Funeral Home</b>		24a. REC'D BY REGISTRAR <b>None</b>	
24b. REGISTRAR'S SIGNATURE <b>None</b>		DATE <b>JUN 19 58</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No. 07200

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASH. D.C.</u> b. COUNTY <u>47x</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHILLUM</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASH. D.C.</u>	
c. LENGTH OF STAY IN 1b <u>7 Mos.</u>		d. STREET ADDRESS <u>3039 Military Rd. N.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Catherine</u> First <u>I</u> Middle <u>S</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>6</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1872</u> 86 yrs.
9. AGE (In years last birthday) <u>86</u>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASH. D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN IRVING</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET McMAHON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>ROBERT T. SMITH - 3039 Military Rd. N.W.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> DUE TO <u>acute coronary occlusion or</u> <u>acute pulmonary embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis gen.</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>3 hours</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> to <u>June 23, 1958</u> , that I lost the deceased on <u>June 23, 1958</u> , and that death occurred at <u>9:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas F. McMahon</u> M.D. <u>3000 Conn. Ave. Wash. 8, D.C.</u>		DATE SIGNED <u>6-23-58</u>	
PHYSICIAN'S NAME (Type) <u>Thomas F. McMahon</u>		ADDRESS <u>3000 Conn. Ave.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-27-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>M.T. OLIVER</u>		22d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Mahlon</u> ADDRESS <u>3831 Oakridge</u>		24. REC'D BY REGISTRAR DATE <u>JUN 30 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>		24c. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

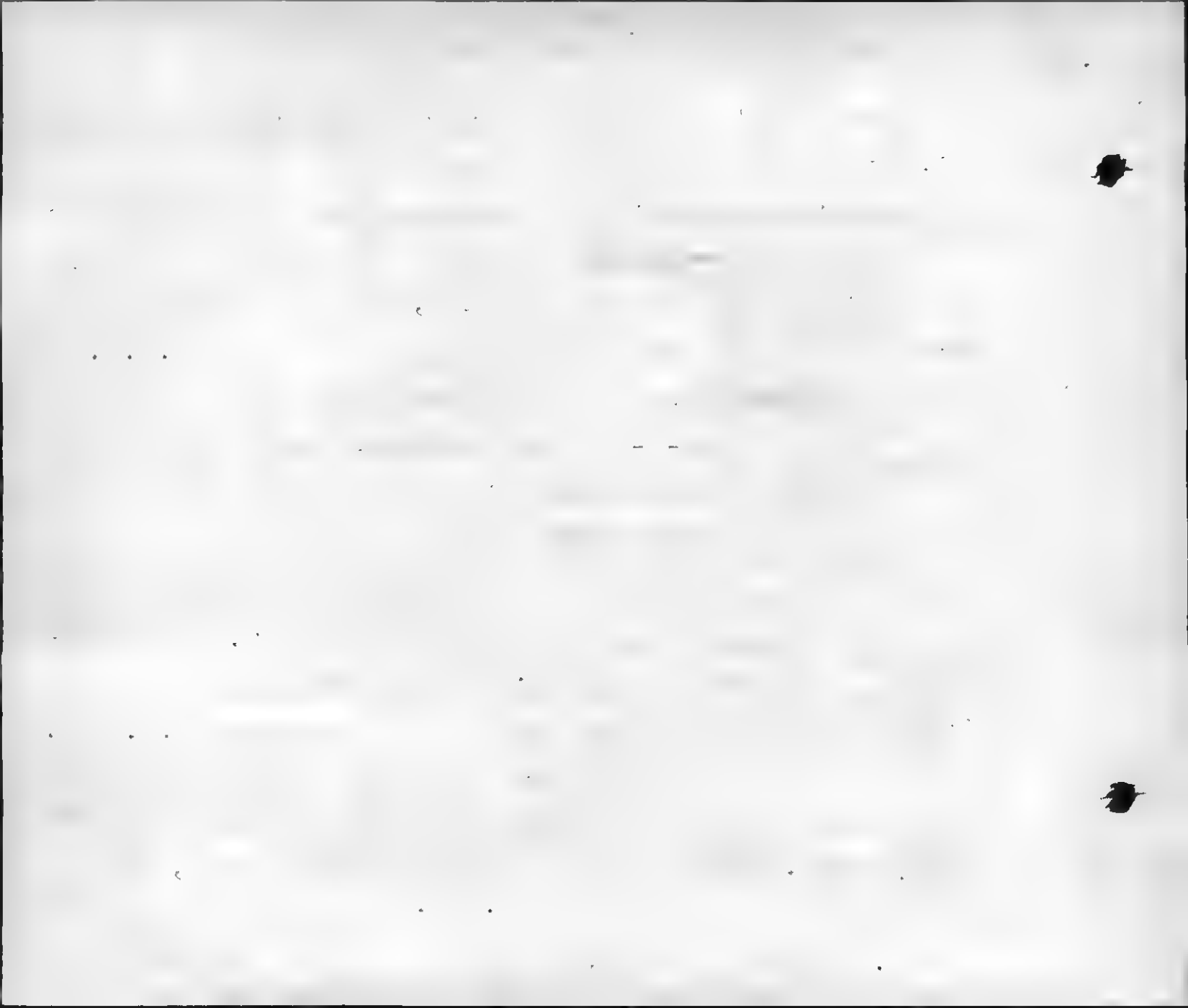
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6729 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07201

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>1 hour</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>2920 Ontario Road</b>	
3. NAME OF DECEASED (Type or print) <b>Stephen Van Rensselaer Spitler</b>		4. DATE OF DEATH <b>June 7 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 20, 1926</b>
9. AGE (In years last birthday) <b>31</b> yrs		10. IF UNDER 1 YEAR <b>7</b> Months <b>17</b> Days <b>17</b> Hours <b>17</b> M'n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>Stephen Van Rensselaer Spitler</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Harrell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO <b>579-30-2679</b>	
17. INFORMANT <b>Patricia Spitler, same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> <b>835X</b> DUE TO <b>Pushed abdomen</b> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Multiple lacerations of head, fractured clavicle, broken rib.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Driver of a stock car that turned over</b>	
20c. TIME OF INJURY <b>1:30</b> m. <b>6/7</b> 19 <b>58</b>	20d. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> <b>Not while at work</b> <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Raceway</b>	20f. (City or town) <b>Upper Marlboro P. G.</b> (County) <b>Md.</b> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>June 7, 1958</b>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/10/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b>	22d. LOCATION (City, town, or county) <b>Arlington</b> (State) <b>Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>755 Wisconsin Ave. Bethesda, Maryland</b>	24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 721 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07202

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Albany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>		c. LENGTH OF STAY IN 1b <u>Transient</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac River</u>		d. STREET ADDRESS <u>525 Central Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>George Edward Stock</u>		4. DATE OF DEATH <u>June 19 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 22, 1924</u>
9. AGE <u>34</u> yrs		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael STACK</u>		14. MOTHER'S MAIDEN NAME <u>Bride Daly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes WWII</u>		16. SOCIAL SECURITY NO. <u>096-14-0109</u>	
17. INFORMANT <u>Navy Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>9298</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Drowning</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Struck while swimming in river</u>	
20c. TIME OF INJURY <u>8:40 a.m. June 19 1958</u>		20d. PLACE OF INJURY (Home, farm, factory, street, office, hotel, etc.) <u>Potomac River</u>	
20e. (City or town) <u>Oxon Hill</u>		20f. (County) <u>Prince Georges</u>	
20g. (State) <u>MD</u>		20h. (City or town) <u>Albany</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL OR CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-24-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Agnes Cemetery</u>		22d. LOCATION (City, town, or county) <u>Albany, New York</u>	
22e. (State) <u>NY</u>		22f. (City, town, or county) <u>Albany</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u>		24. REC'D BY REGISTRAR <u>JUN 23 58</u>	
ADDRESS <u>1400 Chapin St. Washington, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>W.W. Chambers</u>	



7172

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr. Geo. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Seabrook</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hosp</u>				/d STREET ADDRESS <u>Box 38</u>			
3. NAME OF DECEASED (Type or print) <u>John Martin Steele JR</u>				4. DATE OF DEATH <u>June 5 - 1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-18-'31</u>	9. AGE (In years last birthday) <u>27</u> yrs	IF UNDER 1 YEAR: IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physicist U.S. GOVERNMENT</u>				11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Martin Steele</u>				14. MOTHER'S MAIDEN NAME <u>Gladys Fraser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral metastases</u> DUE TO <u>Carcinoma, undifferentiated, primary site undetermined</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Primary site undetermined</u> (c) <u>undetermined</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan 1957</u> , to <u>5 June 1958</u> , that I last saw the deceased alive on <u>5 June 1958</u> , and that death occurred at <u>9:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas G. Maloney</u>				ADDRESS (Street, city or town, state) <u>4814-71st Ave.</u>		DATE SIGNED <u>5 June 1958</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS G. MALONEY</u>				<u>Landoner Nills Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Maryland.</u>		24a. REC'D BY REGISTRAR <u>JUN 9 1958</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



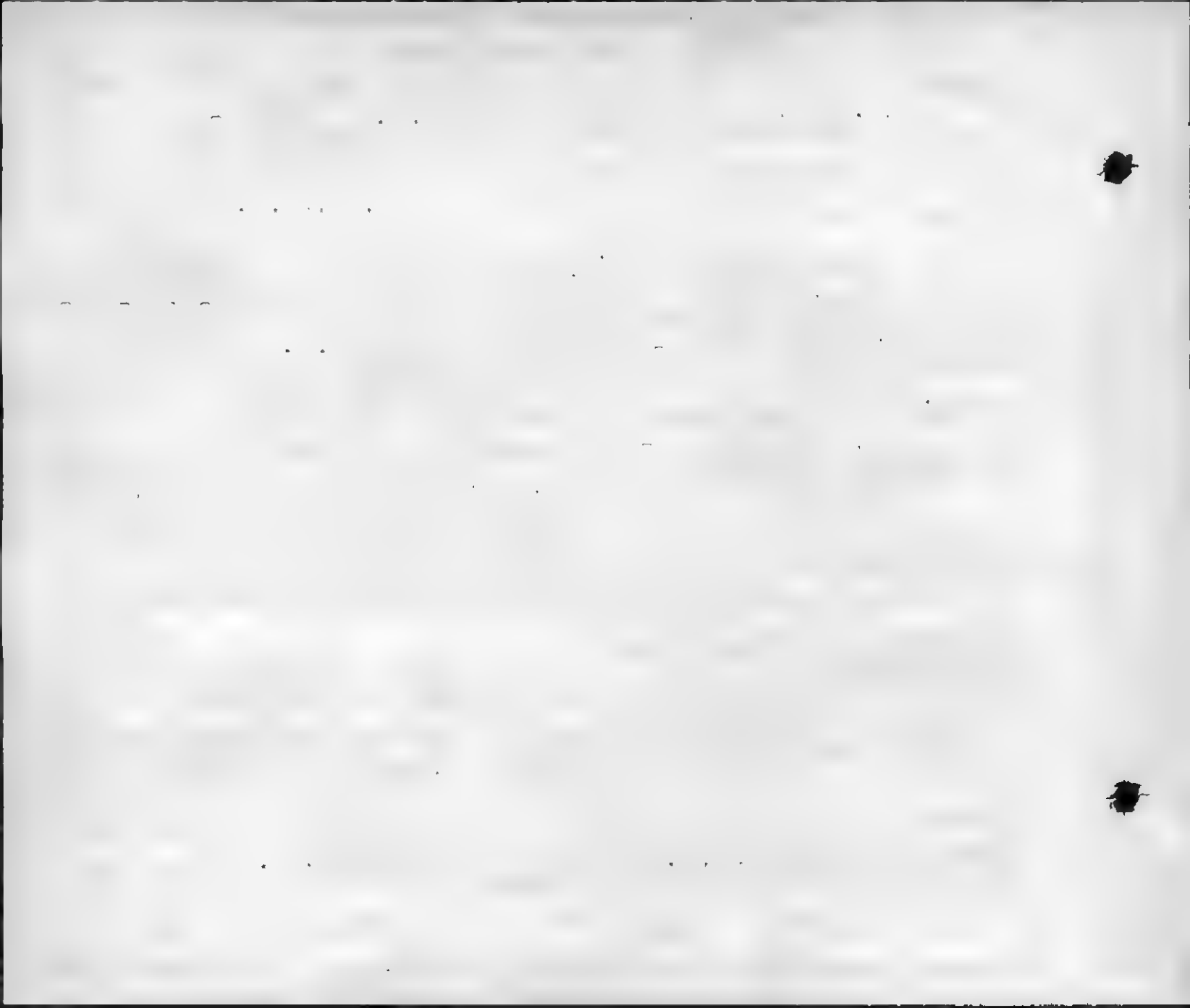


# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7218 CERTIFICATE OF DEATH

Reg. Dist. No.

07204

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>—</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>				c. LENGTH OF STAY IN 1b <b>8 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>				d. STREET ADDRESS <b>409 L. St., N. W.</b>			
3. NAME OF DECEASED (Type or print) First <b>Roosevelt</b> Middle <b>V.</b> Last <b>Stewart</b>				4. DATE OF DEATH Month <b>6</b> Day <b>19</b> Year <b>58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/25/04</b>	
9. AGE (In years last birthday) yrs. <b>53</b>		IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b>		IF UNDER 24 HRS. Hours <b>—</b> Min <b>—</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Radio repairman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>John E. Stewart</b>				14. MOTHER'S MAIDEN NAME <b>Susan Blake</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		(If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO <b>578-12-9628</b>		17. INFORMANT <b>Decedent</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Syn</b> DUE TO (c) <b>10 months</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>6/11</b> , 19 <b>58</b> , to <b>6/19</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>6/18</b> , 19 <b>58</b> , and that death occurred at <b>1:30A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Glenn Dale Hospital</b> DATE SIGNED <b>6/19/58</b> ACTUAL SIGNATURE <b>Moe Weiss</b> M.D. <b>Glenn Dale, Md.</b> PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/25/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hoffman Funeral Home</b>				ADDRESS <b>909-6th St. N.W.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 25 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. J. M. M.</b>							



7173

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md.</b> c. LENGTH OF STAY IN 1b <b>Prince George's Gen. Hospital</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's Gen. Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tuxedo, Md</b> d. STREET ADDRESS <b>4810 Fröhlich Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Taillie, Henry J.</b> First Middle Last <b>Male</b> 5. SEX <b>White</b> 6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>6-27-91</b> 9. AGE (In years last birthday) <b>66</b> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Holland</b> 11. BIRTHPLACE (State or foreign country) <b>U S A</b> 12. CITIZEN OF WHAT COUNTRY?		4. DATE OF DEATH <b>June 9, 1958</b> Month Day Year IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
13. FATHER'S NAME <b>Charles J Taillie</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> 16. SOCIAL SECURITY NO <b>none</b>		17. INFORMANT <b>Charles H Taillie</b> Address <b>Tuxedo Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Fungus</b> DUE TO <b>Perf. Posh left Ventric</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Cor. Thrombosis</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.1</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 5, 1958</b> to <b>June 9, 1958</b> , that I last saw the deceased alive on <b>June 9, 1958</b> , and that death occurred at <b>7:45 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>Hyattsville Md June 9, 1958</b>			
ACTUAL SIGNATURE <b>T. A. Burgman M.D.</b>		M.D. <b>Hyattsville Md.</b>	
PHYSICIAN'S NAME (Type)		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Cremation</b>	<b>6/11/58</b>	<b>Fort Lincoln Crematory</b>	<b>Colmar Manor, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Maryland.</b>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <b>JUN 12 1958</b>		<b>W. H. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7174

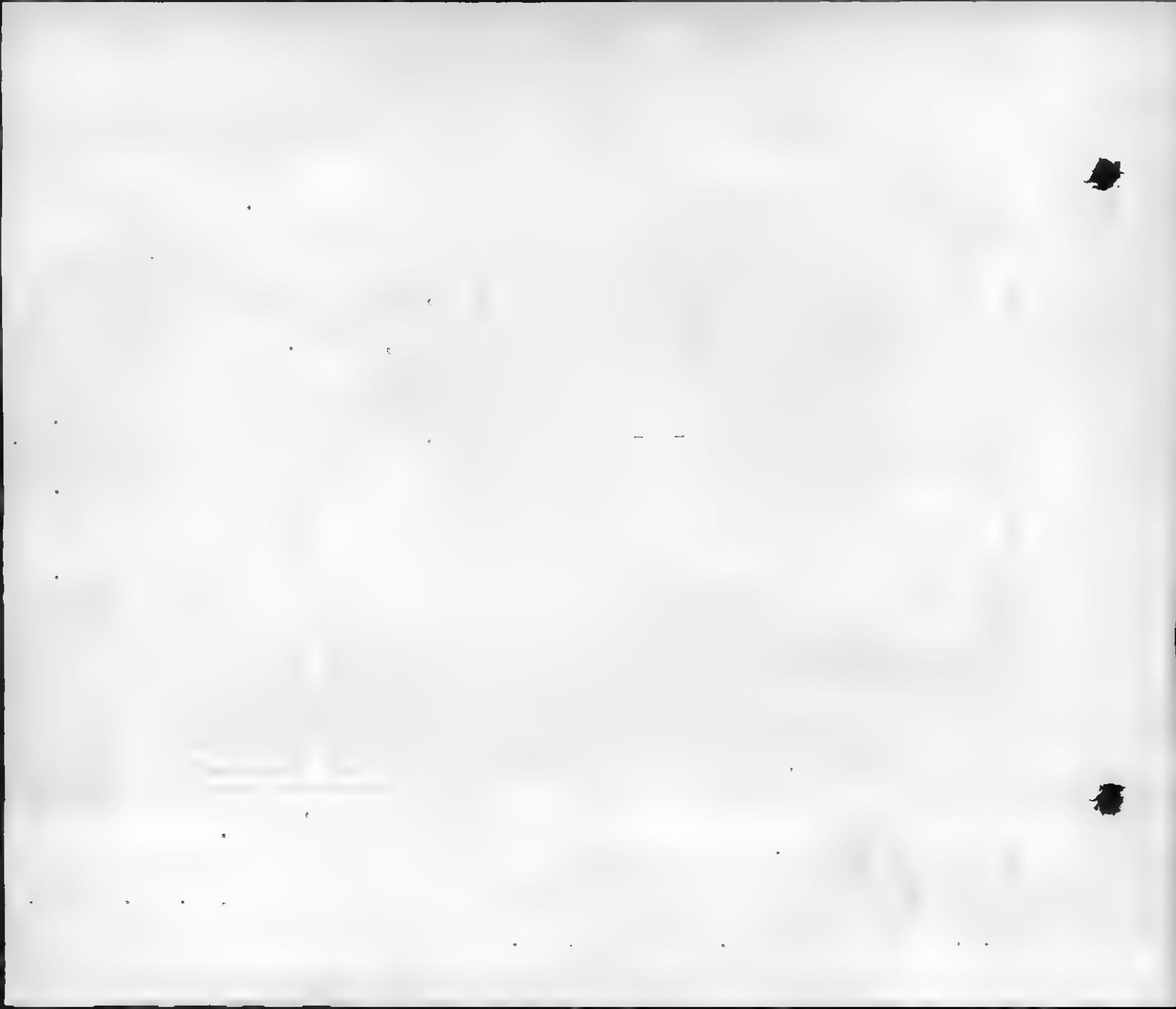
## CERTIFICATE OF DEATH

07206

Reg. Dist. No.

1 PLACE OF DEATH o COUNTY Prince Georges MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b COUNTY Prince Georges			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b 14 da 15 hr			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Leland Memorial Hospital				d. STREET ADDRESS 10601 Baltimore Blvd.			
e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) MORAN First OLIVER Middle TANNER, JR. Last				4. DATE OF DEATH Month June Day 24th, Year 1958			
5 SEX Male		6 COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH May 18th, 1913	
				9 AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Driver				10b KIND OF BUSINESS OR INDUSTRY Greyhound Lines		11. BIRTHPLACE (State or foreign country) Sharon, Penna.	
12 CITIZEN OF WHAT COUNTRY? USA							
13 FATHER'S NAME Moran Oliver Tanner				14 MOTHER'S MAIDEN NAME Bertha Fern Jenks			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) None				16 SOCIAL SECURITY NO 225-05-1379		17 INFORMANT Address Beltsville, Md Dorothy L. Tanner, 10601 Baltimore Blvd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia (Terminal)							
DUE TO Cerebral Hemorrhage							
DUE TO Essential Hypertension							
INTERVAL BETWEEN ONSET AND DEATH 48 hrs.							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c TIME OF INJURY Month, Day, Year 1958							
20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f (City or town) (County) (State)							
21. I certify that I attended the deceased from June 8th, 1958, to June 24th, 1958, that I last saw the deceased alive on June 23rd, 1958, and that death occurred at 3:30 AM, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 6220 Ager Road, West Hyattsville, Md.							
DATE SIGNED 6/24/58							
ACTUAL SIGNATURE Ernest J. Parent M.D.							
PHYSICIAN'S NAME (Type) Ernest J. Parent							
22a BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/27/1958		22c NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co., Md.	
23 FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a REC'D BY REGISTRAR DATE JUN 27 58		24b REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

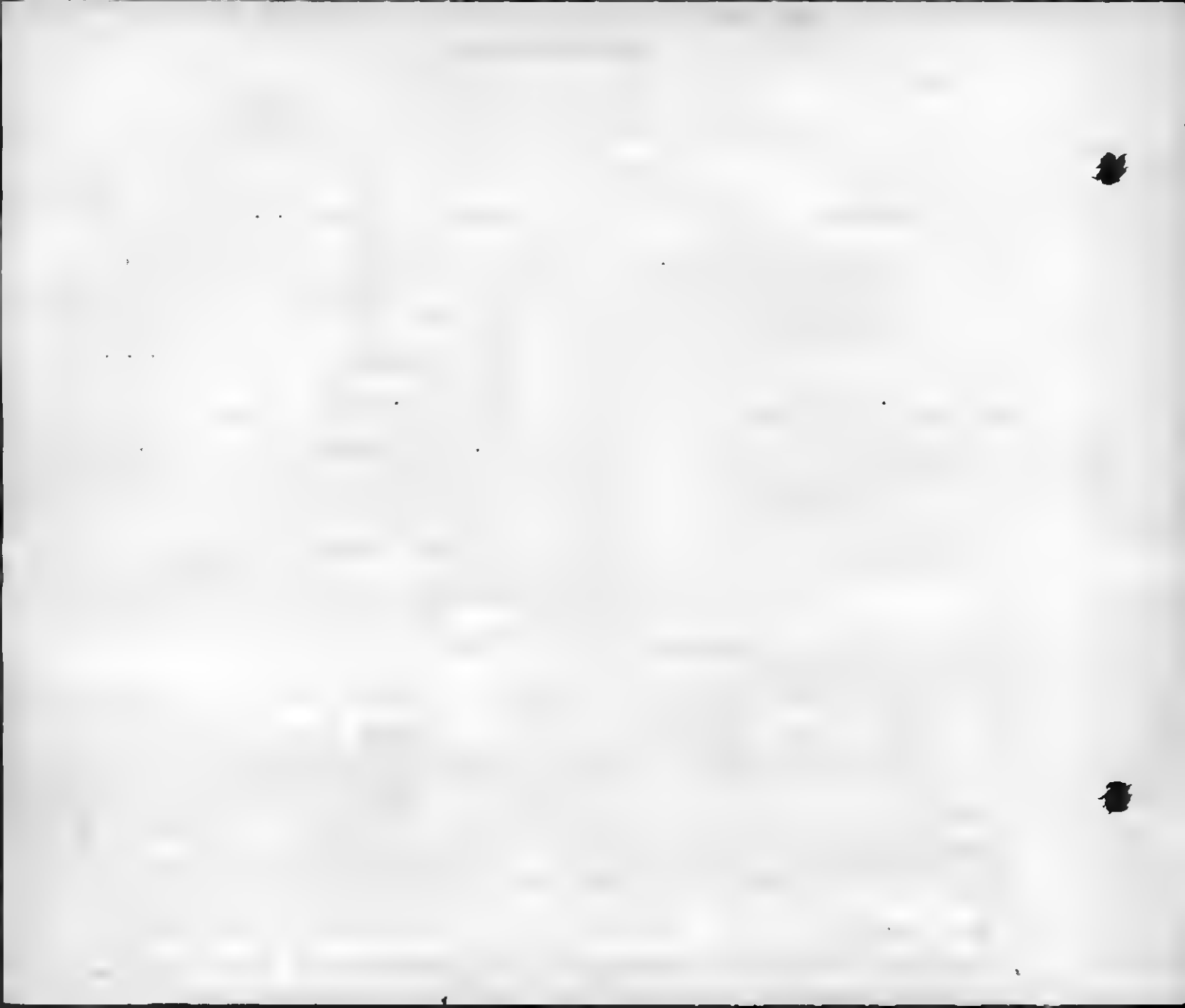
7118

## CERTIFICATE OF DEATH

07207

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>				c. LENGTH OF STAY IN lb <b>6 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CARROLL MANOR</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> <b>47A</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <b>249 8th Street, N.E.</b>			
3. NAME OF DECEASED (Type or print) <b>FRANCES E. TAYLOR</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>9</b> Year <b>1958</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOVEMBER 23, 1874</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Special Policewomen</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		11. BIRTHPLACE (State or foreign country) <b>Salem, New Jersey</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>WILLIAM H. TAYLOR</b>			
14. MOTHER'S MAIDEN NAME <b>ALICE A. MILLS</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>SISTER M. JOAN THERESE</b> Address <b>4922 LaSalle Rd.,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>18 YEARS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CARCINOMA OF RIGHT BREAST (1-2 YRS. DURATION)</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1946</b> , to <b>June 9</b> , 1958, that I last saw the deceased alive on <b>June 8</b> , 1958, and that death occurred at <b>3:15 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John F. Finnegan</b> M.D.				ADDRESS (Street, city or town, state) <b>1746-K St., N.W., Wash. DC</b>			
DATE SIGNED <b>6/9/58</b>				DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>JOHN F. FINNEGAN</b>				ADDRESS (Street, city or town, state) <b>1746-K St., N.W., WASHINGTON, DC</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>6-11-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>East Lincoln Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Calver Manor, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. William Leisner</b> ADDRESS <b>300-48 NE DC</b>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <b>Lee</b>	
DATE <b>JUN 11 '58</b>				DATE			





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7219 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07208

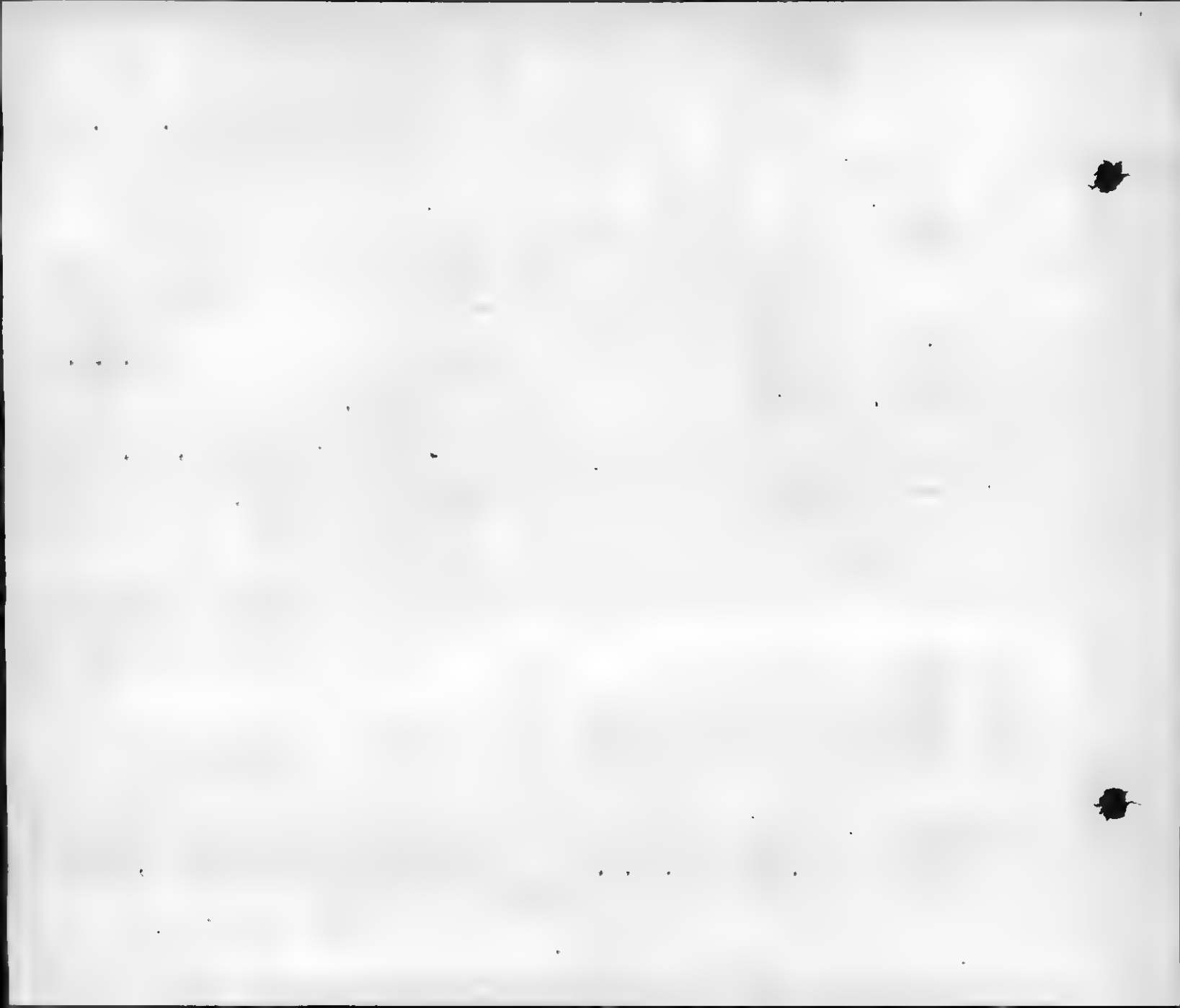
FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>Bowie</b>	
c. LENGTH OF STAY IN lb <b>31 years</b>		d. STREET ADDRESS <b>Hillmead Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hillmead Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George Elbert Taylor</b>		4. DATE OF DEATH <b>June 26 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-21-87</b>
9. AGE (In years last birthday) <b>71 yrs.</b>		10. IF UNDER 1 YEAR: Months <b>71</b> Days <b>26</b> Hours <b>19</b> Min <b>58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John R. Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Sarah E. Marshall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Bertram E. Taylor; Muirkirk, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular renal disease.</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. <b>DUE TO</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>June 26, 1958</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/28/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Trinity Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Collington Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		24a. REC'D BY REGISTRAR <b>W. H. Gasch</b>	
ADDRESS <b>Hyattsville Md.</b>		DATE <b>JUN 30 '58</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 717 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

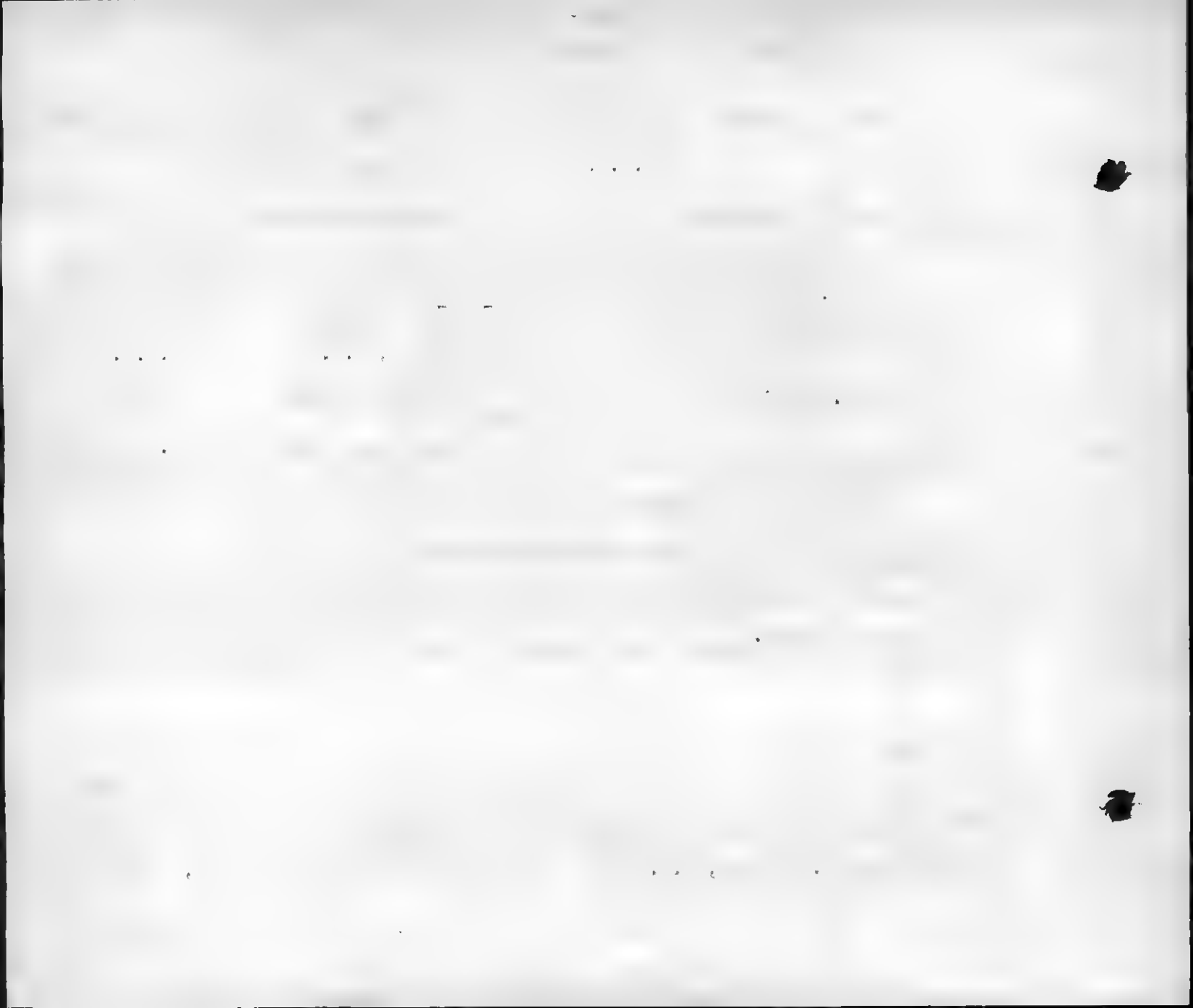
07209

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Patricia Jolene Tripi</b>		4. DATE OF DEATH <b>June 20 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-25-49</b>
9. AGE (In years last birthday) <b>8</b> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph B. Tripi</b>		14. MOTHER'S MAIDEN NAME <b>Edith Sullinger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Joseph Tripi; same address as # 2.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Toxemia</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Bilateral lobar pneumonia</b> (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral palsy.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>June 20, 1958</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/23/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Malley's Funeral Home</b>		ADDRESS <b>mt Rainier, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE JUN 25 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 7176 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

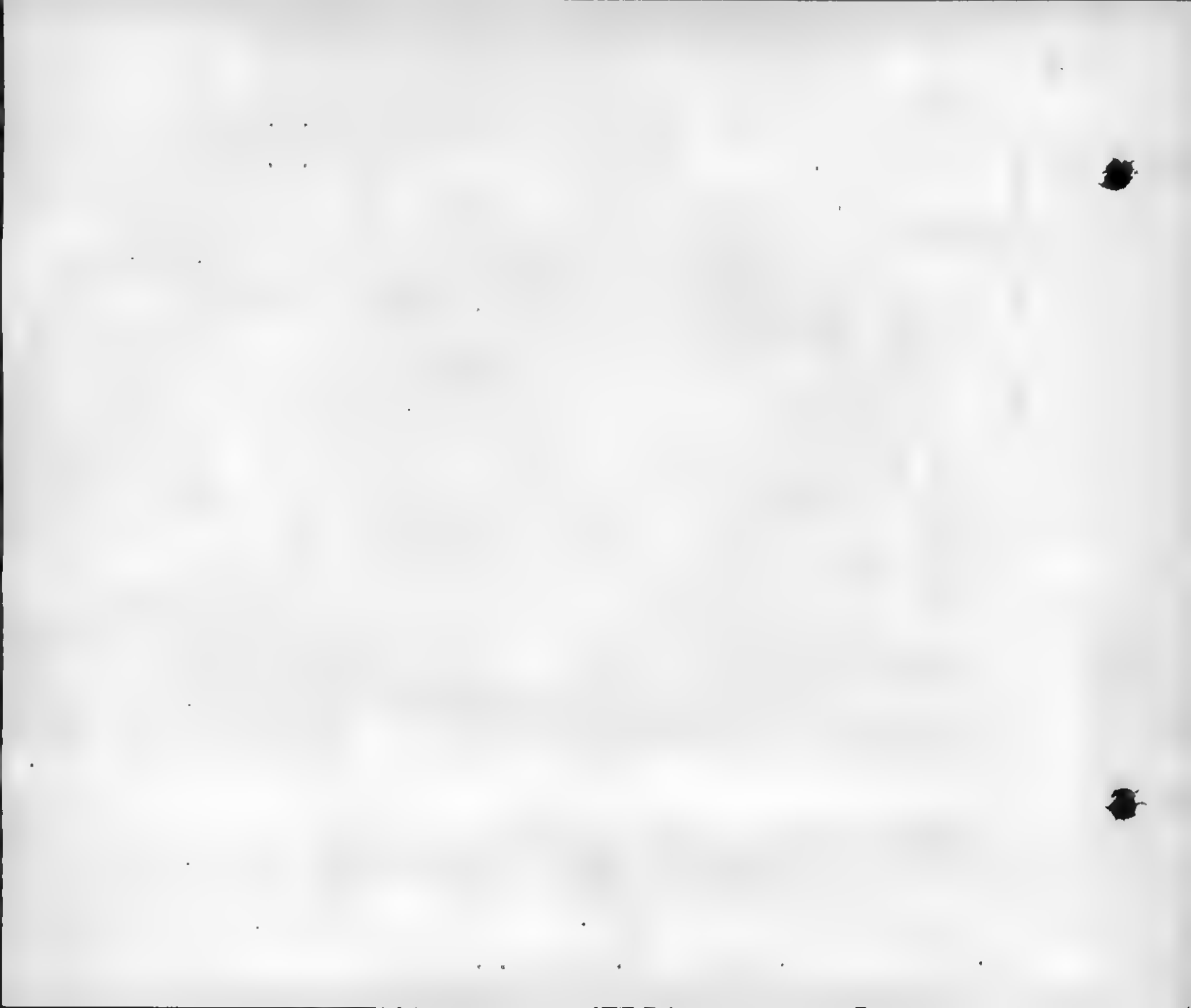
07210

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Washington D. C.</b> b. COUNTY <b>Washington D. C.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly Md.</b>				c. LENGTH OF STAY IN 1b <b>2 hours</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>				e. STREET ADDRESS <b>816 K Street N E</b>			
3. NAME OF DECEASED (Type or print) <b>Samuel Tyndle</b>				4. DATE OF DEATH Month <b>June</b> , Day <b>1</b> , Year <b>1958</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 2, 1921</b>		9. AGE (In years last birthday) <b>27</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dairy</b>		11. BIRTHPLACE (State or foreign country) <b>Lawndale N C</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Ralph Tyndle</b>				14. MOTHER'S MAIDEN NAME <b>Marie Haygood</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W W 11</b>		17. INFORMANT <b>Ralph Tyndle Lawndale North Carolina</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: (a) <b>Stomach ache and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Crushed chest</b> DUE TO (c)</p> </div> <div style="width: 35%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Pancreas in auto that ran off Road</b>					
20c. TIME OF INJURY Month, Day, Year <b>June 1 1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, office bldg., etc.) <b>Route 4</b>		20f. (City or town) <b>Forestville P. D. Ind</b> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James I. Boyd</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>June 1, 1958</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6/2/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SHELBY N.C.</b>		22d. LOCATION (City, town, or county) (State) <b>SHELBY N.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. ERNEST JARVIS CO.</b>				24a. REC'D BY REGISTRAR <b>DATE JUN 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Ernest Jarvis</b>	



7177

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) 4114--54th Street				d. STREET ADDRESS 4114--54th Street, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HENRY MICHAEL UFFELMAN				4. DATE OF DEATH Month Day Year June 11th, 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25th, 1890		9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station Operator				10b. KIND OF BUSINESS OR INDUSTRY (Gasoline)		11. BIRTHPLACE (State or foreign country) Oakdale, Penna.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Rhinehart Uffelman			
14. MOTHER'S MAIDEN NAME Helen Shaffer				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None (If yes, give year or dates of service) None			
16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Myrtle M. Uffelman, 4114--54th St. Address Bladensburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO Carcinoma of Kidney Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Kidney (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 yr 5 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from May 15, 1958, to June 11, 1958, that I last saw the deceased alive on June 10, 1958, and that death occurred at 8:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 5102 Annapolis Road 6/11/1958 Bladensburg, Md.							
ACTUAL SIGNATURE Julius Kauffman M.D.							
PHYSICIAN'S NAME (Type) Julius Kauffman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/11/1958	22c. NAME OF CEMETERY OR CREMATORY Montour Cemetery		22d. LOCATION (City, town or county) (State) Oakdale, Penna.		
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md. ADDRESS				24a. REC'D BY REGISTRAR DATE JUN 13 '58		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





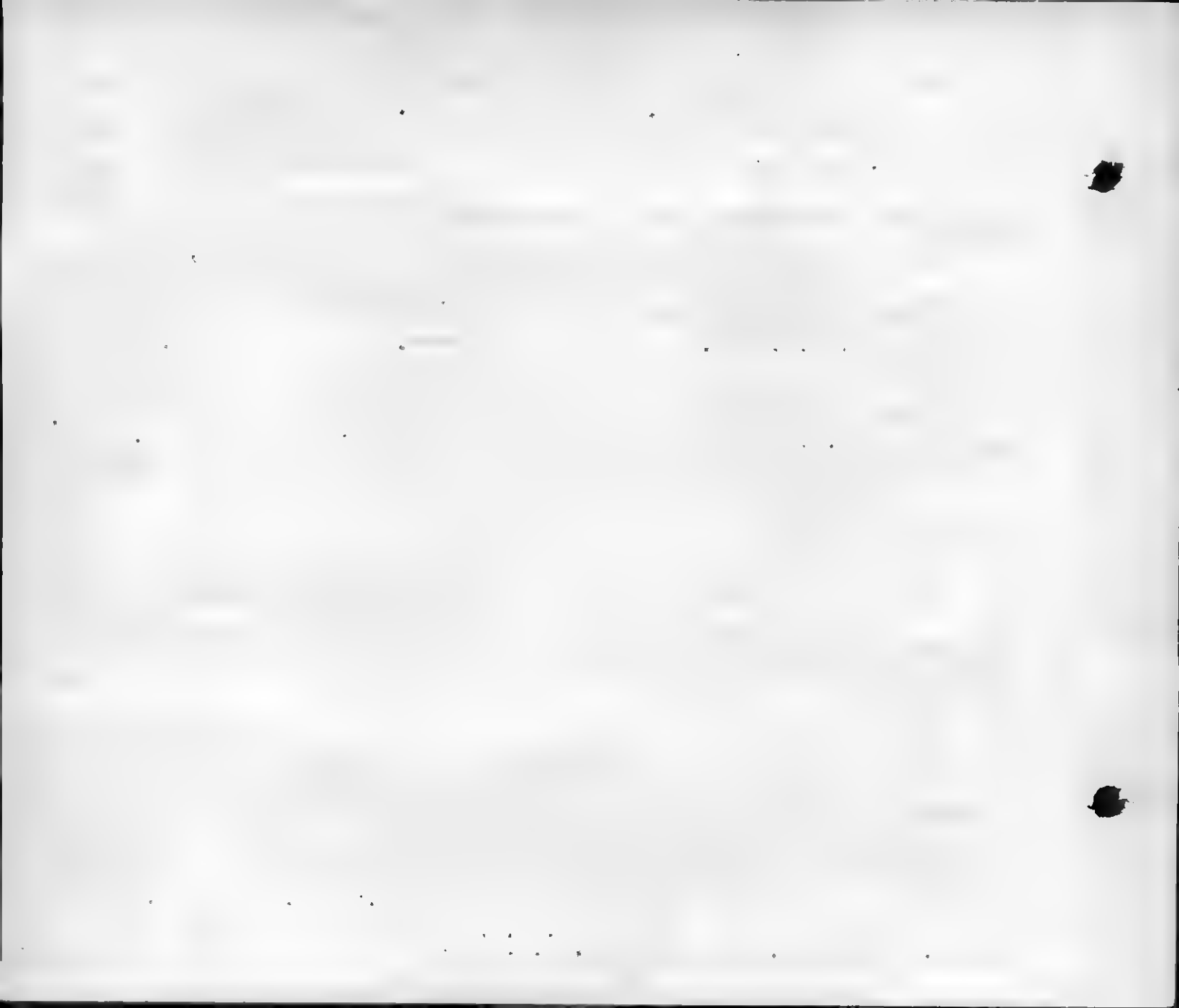
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7119 Item 9 F 1-1-58  
CERTIFICATE OF DEATH

07212

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4701 27th Street				d. STREET ADDRESS 4701 27th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last WALTER UTMAN				4. DATE OF DEATH Month Day Year June 14, 1958 19			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 1, 1902	
9. AGE (In years last birthday) 55 56 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant, U.S. Govt.		11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Commodore Utman				14. MOTHER'S MAIDEN NAME Catherine Hicks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes W.W.# 1				16. SOCIAL SECURITY NO.		17. INFORMANT Address Md. Chester Gierula, 13027 Matey Rd., Wheaton	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH June 14	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from MAY 1, 1958, to JUNE 14, 1958, that I last saw the deceased alive on JUNE 13, 1958, and that death occurred at 12:00 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Irvin M. Grassgreen M.D. 201 ARUNDEL RD. PHYSICIAN'S NAME (Type) IRVIN M. GRASSGREEN							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6/18/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Ft. Myer, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wash, D.C. The S.H.Hines Co., 2901 14th St. N.W.				24a. REC'D BY REGISTRAR DATE JUN 11 58		24b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

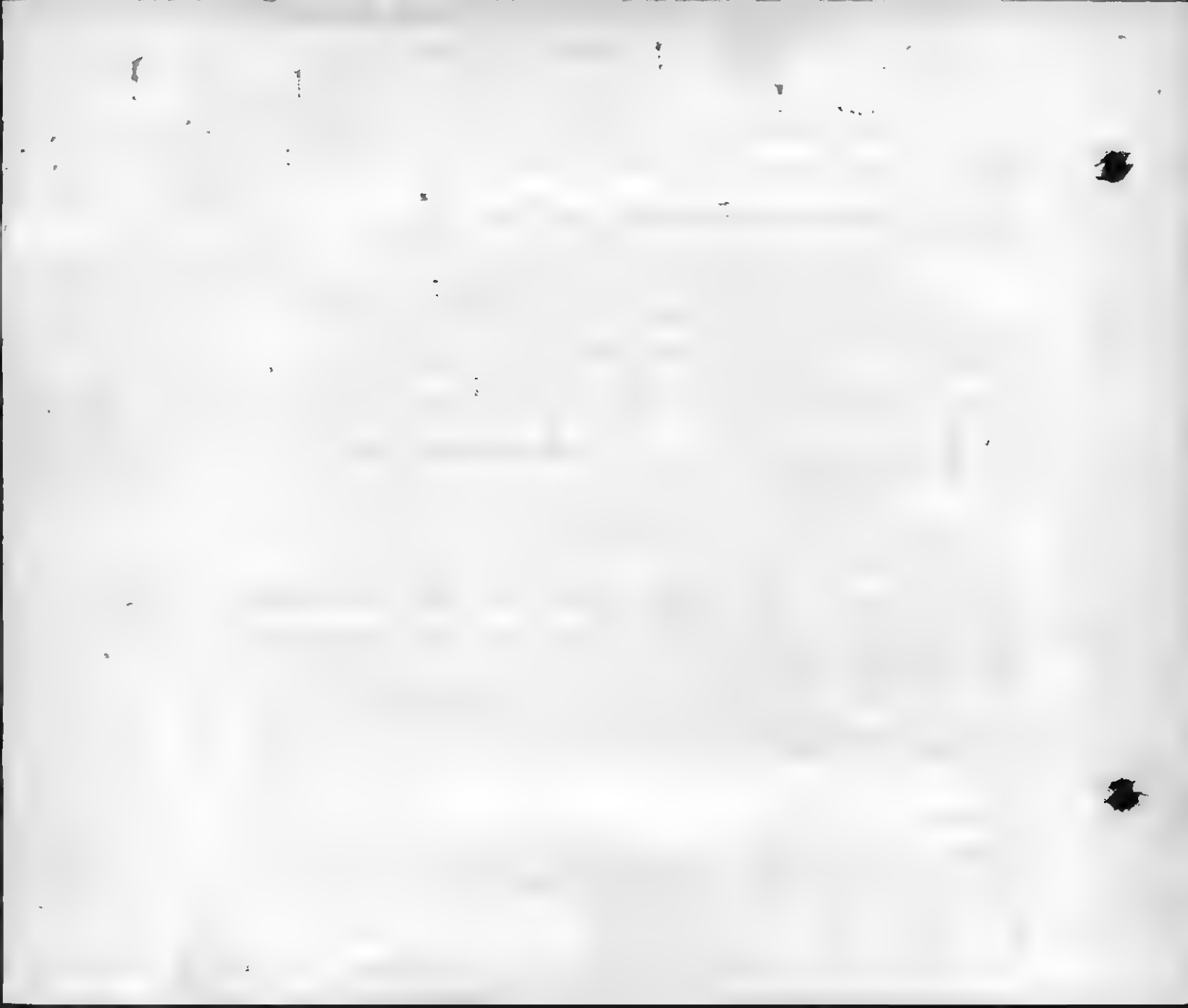
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7220

## CERTIFICATE OF DEATH

Reg. Dist. No. 07213

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, give name of institution. If residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Morningside</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Morningside</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>217 Woodland Road</u>				d. STREET ADDRESS <u>217 Woodland Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bernard F.</u> Middle <u>Valentine</u> Last <u>Valentine</u>				4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1906</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u>15</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Warehouseman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harz Sanitary</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William R. Valentine</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Reynolds</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>233-65-4702</u>		17. INFORMANT Name <u>Mrs Pauline W. Valentine</u> Address <u>217 Woodland Rd Morningside, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, Colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>o. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>56</u> , to <u>June 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 8</u> , 19 <u>58</u> , and that death occurred at <u>2 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Eugene Cole</u> M.D. <u>639 E. Capitol St. D.C.</u> PHYSICIAN'S NAME (Type) <u>Eugene Cole M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-11-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		22d. LOCATION (City, town, or county) _____ (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers &amp; Co. Washington. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7178

## CERTIFICATE OF DEATH

07214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly, Md</b>			c. LENGTH OF STAY IN 1b <b>2 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Carmody Hills, Md</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				d. STREET ADDRESS <b>506 73rd St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>R.</b> Last <b>Walter</b>				4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-14-21</b>	
9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>8</b> Hours <b>1</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cable Splicer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C&amp;P Telephone Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>					
13. FATHER'S NAME <b>Harvey R Walter</b>				14. MOTHER'S MAIDEN NAME <b>Jane Karle</b>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>W W 11</b>		17. INFORMANT <b>Lois Walter (Wife)</b>		Address <b>Same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>1. Coronary Thrombosis</b> <b>420.1</b> DUE TO <b>Coronary Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b> <b>1 year</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 7, 1958</b> , to <b>June 9, 1958</b> , that I last saw the deceased alive on <b>June 9, 1958</b> , and that death occurred at <b>1:20 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Norman D. Rush</b>				ADDRESS (Street, city or town, state) <b>3503 Perry St</b>		DATE SIGNED <b>6/9/58</b>	
PHYSICIAN'S NAME (Type) <b>Dr. N. Comeau</b>				M.D. <b>MT Rainier Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transportation 6/10/58</b>		22b. DATE THEREOF <b>6/10/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Altoona</b>		22d. LOCATION (City, town, or county) (State) <b>Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 12 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Altoona</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

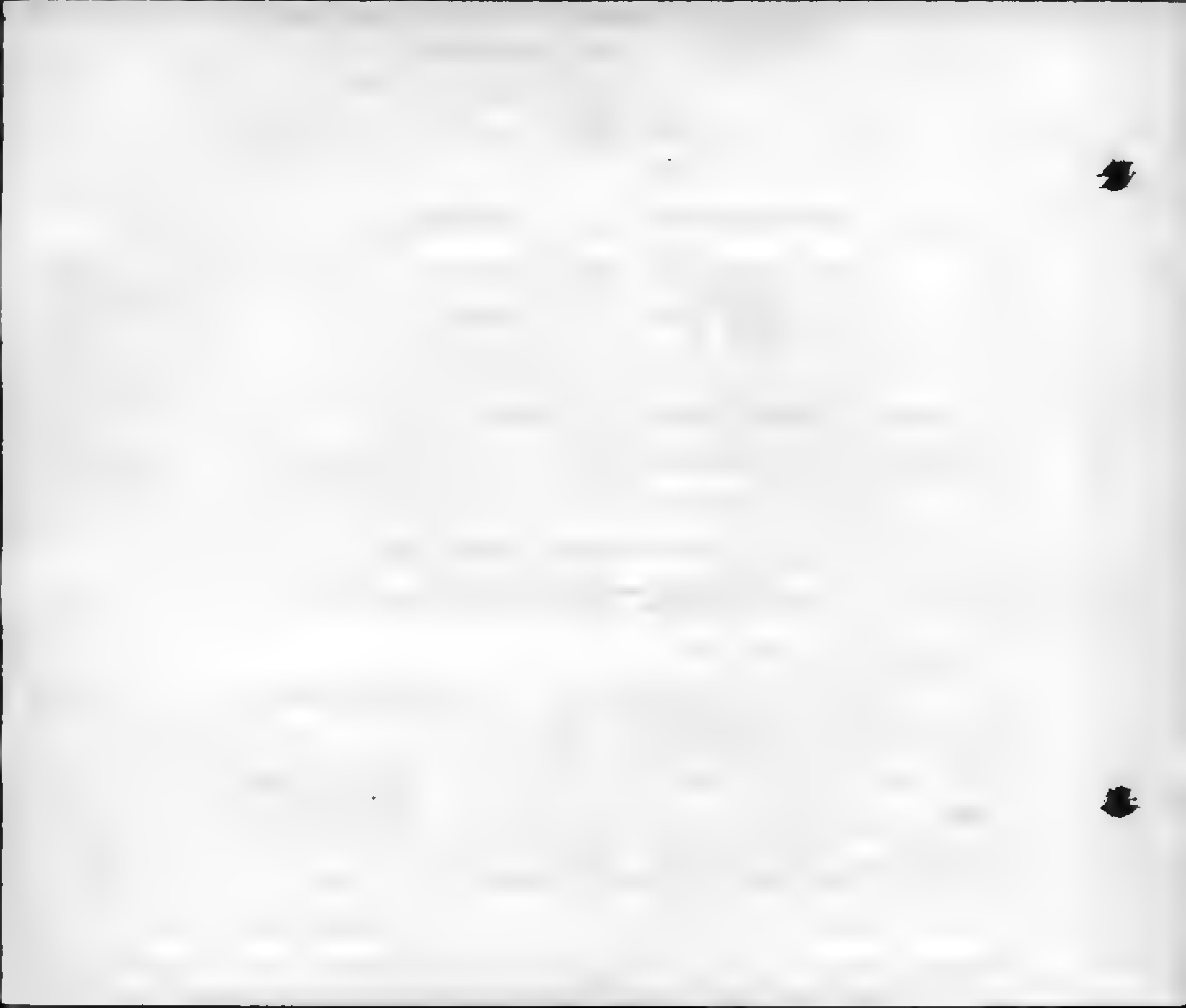


# CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. [redacted] may be retained [redacted] hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and [redacted] completely filled in by the funeral director, [redacted] page 3 should be [redacted] held for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registrar prior to burial, cremation, or [redacted] and in any event within 72 hours after death.

VS A15 (4)  
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7222

## CERTIFICATE OF DEATH

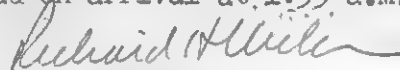
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHELTENHAM</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHELTENHAM</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSP ANDREWS A.F. Base</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>OLIVER</b> Last <b>WARNER</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>27</b> Year <b>1958</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 21 1916</b>	9. AGE (In years last birthday) <b>42</b> yrs.	IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	IF UNDER 24 HRS. Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PILOT USAF</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USAF</b>		11. BIRTHPLACE (State or foreign country) <b>MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>GEORGE O. WARNER</b>				14. MOTHER'S MAIDEN NAME <b>GRACE C. BRADY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give year or dates of service) <b>19 years</b>		16. SOCIAL SECURITY NO. <b>513-20-6240</b>		17. INFORMANT <b>USAF Personnel Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute CORONARY OCCLUSION with</b> <b>4 x 4.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1 HOUR</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <b>19</b> Day <b>19</b> Year <b>1958</b> Hour <b>a. m.</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>D.O.A.</b> , 19 <b>—</b> , to <b>JUNE 27</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>—</b> , 19 <b>—</b> , and that death occurred at <b>1:15 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Richard H. Weber</b>				ADDRESS (Street, city or town, state) <b>1001st USAF HOSP</b>			
DATE SIGNED <b>JUNE 27, 58</b>							
PHYSICIAN'S NAME (Type) <b>RICHARD H. WEBER</b>				ADDRESS <b>ANDREWS A.F. Base Wash 25, D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-2-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co. Inc. 517-11th St. &amp; E.</b>				24a. REC'D BY REGISTRAR <b>—</b>		24b. REGISTRAR'S SIGNATURE <b>—</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

I, the undersigned do hereby certify that while in performance of my duties as Medical Officer of the Day at 1001st USAF Hospital, Andrews Air Force Base, Washington 25, D.C. I received a call from wife of deceased, describing severe chest pains and requesting medical advice. I immediately dispatched an ambulance to home of deceased and had him transported to this facility, pronouncing him dead on arrival at 1:55 a.m.



RICHARD H. WEBER  
CAPT, USAF (MC)  
Attending Physician

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7223 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07217

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Danvers</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Danvers</u>	
c. LENGTH OF STAY IN 1b <u>2 years</u>		d. STREET ADDRESS <u>515-8th Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>515-8th Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eleanor Bernadette Wattans</u>		4. DATE OF DEATH <u>June 23 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-2-19</u>
9. AGE (In years and birth day) <u>39 yrs</u>		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Sidney Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Sadie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Joseph C. Wattans - Same address</u>	
17. INFORMANT <u>Joseph C. Wattans - Same address</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>465X</u> DUE TO <u>Pulmonary infarction</u>		INTERVAL BETWEEN ONSET AND DEATH	
(b) <u>Pulmonary embolism</u>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John T. Maloney</u>		DATE SIGNED <u>June 23, 1958</u>	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, MD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/26/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>7 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



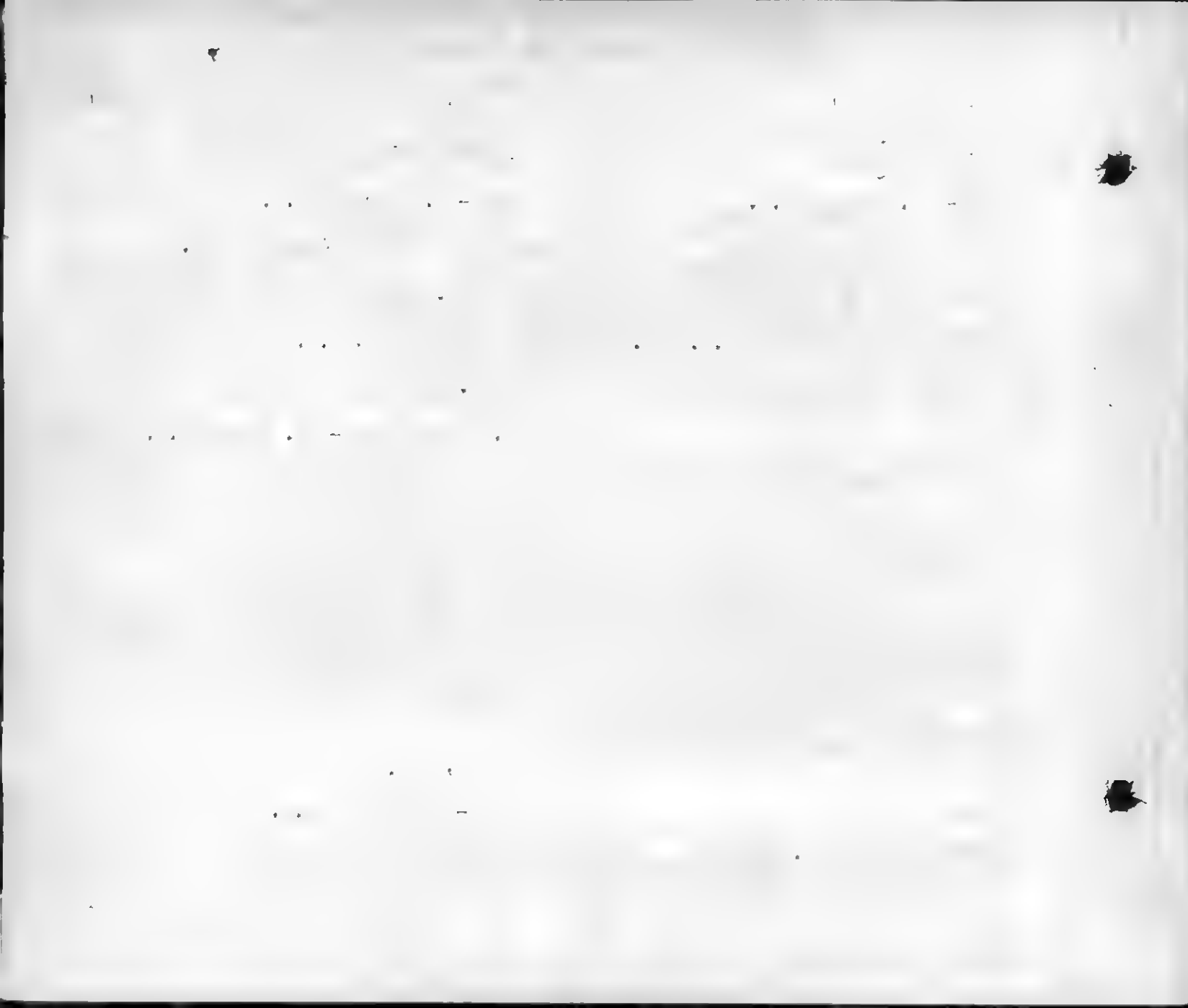
7224

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bradbury Heights</b>		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bradbury Heights</b>	
c. LENGTH OF STAY IN 1b <b>35 Years</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) <b>4808- V. Street S.E.</b>	
d. STREET ADDRESS <b>4808 - V. Street S.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HERBERT</b>		4. DATE OF DEATH Month <b>June</b> Day <b>1st.</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 9th. 1887</b>
9. AGE (In years last birthday) yrs <b>70</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>D.O. Gov. Mechanic</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>George Webster</b>	
14. MOTHER'S MAIDEN NAME <b>Ann J. Savage</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Nola B. Webster 4808- V. Street S.E. (Wife)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA TO BRAIN</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>BRONCHIOGENIC CARCINOMA</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4/18/58</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pleural Effusion</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/18</b> , 19 <b>58</b> to <b>5/31</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5/31</b> , 19 <b>58</b> , and that death occurred at <b>2:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4400- Bowen Road S.E.</b> DATE SIGNED <b>June 1st 58</b>			
ACTUAL SIGNATURE <b>Thomas F. Cullen</b>		M.D. <b>4400- Bowen Road S.E.</b>	
PHYSICIAN'S NAME (Type) <b>THOMAS F. CULLEN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial June 4-58</b>	<b>June 4-58</b>	<b>Cedar Hill Cemetery</b>	<b>Smithland Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Bros</b>		ADDRESS <b>1661- grand Ave. Rd</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7179

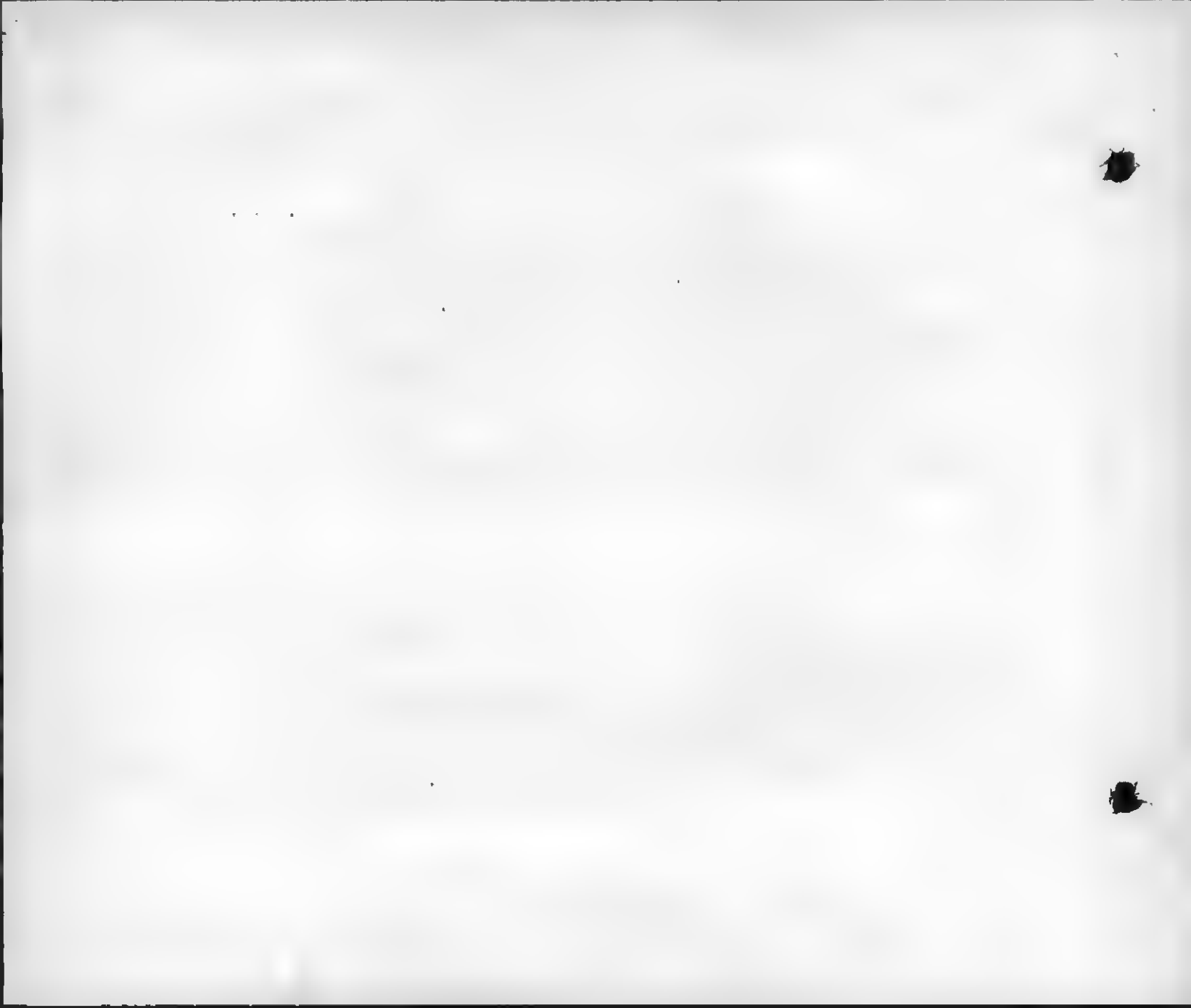
## CERTIFICATE OF DEATH

Reg. Dist. No.

07219

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>	c. LENGTH OF STAY IN 1b <b>25 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Washington ??</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>1100 50th Ave. S.E.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Elvira</b> First <b>M.M.N.</b> Middle <b>Wells</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 Dec. 1906</b>
9. AGE (In years last birthday) yrs. <b>51</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	
11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>Yes</b>	
17. INFORMANT <b>Mardie Wells</b>		Address <b>1409-50th Ave. S.E.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Pyelonephritis &amp; abscess</b> DUE TO <b>Concomitant to the formation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>urethra</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ P. M. from the causes and on the date stated above <b>9:15 - 19 58</b> ADDRESS (Street, city or town, state) <b>Wash. D.C.</b> DATE SIGNED <b>7/4/58</b>			
ACTUAL SIGNATURE <b>Louis B. Bachrach MD</b>		PHYSICIAN'S NAME (Type) <b>Wash. D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-7-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Lincoln Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Bladensburg Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co. Inc</b>		ADDRESS <b>577-11th St S.E.</b>	24a. REC'D BY REGISTRAR DATE <b>JUN 6 '58</b>
		24b. REGISTRAR'S SIGNATURE <b>W. W. Chambers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





7180

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 2507 Bucklodge Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frank		First Middle Last MARTIN Williams		4. DATE OF DEATH June 14 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-2-58	
				9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter Williams				14. MOTHER'S MAIDEN NAME Martha Jane Storm			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		(If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Walter F. Williams—Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Birth injury DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 12.1.13	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-2-1958 to 6-14-1958, that I lost saw the deceased alive on 6-14-1958, and that death occurred on 1:20 P.M. from the causes and on the date stated above							
ACTUAL SIGNATURE R.D. BAWER, M.D.				ADDRESS (Street, city or town, state) 2507 Bucklodge Rd. Adelphi, Md.			
PHYSICIAN'S NAME (Type) R.D. BAWER, M.D.				DATE SIGNED 6-14-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 16, 1958		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE JUN 17 1958		24b. REGISTRAR'S SIGNATURE O. L. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 7225  
 CERTIFICATE OF DEATH

07221

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>-</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
c. LENGTH OF STAY IN 1b <u>1 yr., 3 mos., 8-11 days</u>				d. STREET ADDRESS <u>2370 Champlain St., N.W.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Gilbert</u> Middle <u>B.</u> Last <u>Wilson</u>				4. DATE OF DEATH Month <u>6</u> Day <u>5</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED, not legally <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/19/13</u>	
9. AGE (In years, last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>		IF UNDER 24 HRS Hours <u>-</u> Min <u>-</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Burlington Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Clarence G. Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Ethel Pate</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-18-3166</u>		17. INFORMANT <u>Decedent</u>		Address <u>-</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Atherosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>002X</u> (b) <u>-</u> (c) <u>-</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>14</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY TUBERCULOSIS BICHOIRIAL ASTHMA COK. PULMONARY HEMORRHAGE PANCREATITIS</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>0. 11</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>2/25</u> , 19 <u>57</u> , to <u>6/5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/5</u> , 19 <u>58</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Moe Weiss</u>				ADDRESS (Street, city or town, state) <u>Glenn Dale Hospital</u> DATE SIGNED <u>6/5/58</u>			
PHYSICIAN'S NAME (Type) <u>Moe Weiss, M. D.</u>				Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>6/6/58</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. McHenry</u>				ADDRESS <u>1820-9th St. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. J. Schuch</u>			



7181

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>41 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairmont Heights</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George Genral Hospital</b>				f. STREET ADDRESS <b>1013 58th Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Wilson</b> Last <b>Wilson</b>			4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>19 58</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Black</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 Nov 1889</b>		9. AGE (In years last birthday) yrs. <b>68</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian, School</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Montgomery Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Dick Wilson</b>			14. MOTHER'S MAIDEN NAME <b>Emma P. (Maiden name unknown)</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple cerebral infarcts</b> DUE TO <b>Sudo carditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of the body of the pancreas</b> DUE TO (c) <b>1 yr.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>41 days</b> <b>41 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <b>4/26</b> , 19 <b>58</b> to <b>6/6</b> , 19 <b>58</b> that I last saw the deceased alive on <b>6/6</b> , 19 <b>58</b> , and that death occurred at <b>4.00A</b> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Norman Daniel Comeau</b>		ADDRESS (Street, city or town, state) <b>3503 Perry St.</b>		DATE SIGNED <b>6/6/58</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Norman Comeau MD</b>		<b>24 T Romaine Rd</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, county) (State)			
<b>Burial</b>	<b>6/9/58</b>	<b>Woodlawn</b>		<b>Washington D.C.</b>			
Robert G. Mason Funeral Home, Inc 2500 Nichols Ave, S.E. Wash. D.C.				24a. REC'D BY REGISTRAR DATE <b>JUN 12 '58</b>			
				24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>			

CERTIFICATE OF DEATH

1. Name of deceased: John A. Smith  
2. Date of death: Jan 15 1900  
3. Place of death: at home  
4. Age: 45  
5. Sex: Male  
6. Cause of death: Heart Disease  
7. Signature of physician: Dr. J. B. Smith  
8. Signature of registrar: John A. Smith  
9. Date of registration: Jan 15 1900

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07223  
7182 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>N. E.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesley</b>		c. LENGTH OF STAY IN 1b <b>Dead on arrival</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		472-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>1701 M st., N.E.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED <b>Glentina Ella Frazier Woods</b>		4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>1958</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>14 March</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Presser</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Simas</b>		14. MOTHER'S MAIDEN NAME <b>Annie Young</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) <b>No</b> (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578058209</b>	
17. INFORMANT <b>Albert B. Frazier</b>		1606 Indiana Ave., S.E. Washington, D. C. Son	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Crushed chest</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) <b>Occupant of an automobile that ran off road and struck tree</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>9:30</b> p. m. <b>6/16</b> <b>1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Tucker Road</b>		20f. (City or town) <b>Oxon Hill</b> (County) <b>P. G.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>June 16, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/19/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chas. J. Stewart</b>		24a. REC'D BY REGISTRAR <b>June 18 '58</b>	
30 H Street, N.E.		24b. REGISTRAR'S SIGNATURE <b>Robert Smith</b>	

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